Will his return to work mean the return of undue psychic tension?

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Valium® (diazepam)

For the tense cardiac patient who must be kept calm

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to Paradoxical reactions such as acute hyperexcited states, anxiety, hallucin tions, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; shou these occur, discontinue drug. Isolate reports of neutropenia, jaundice; periodic blood counts and liver functi tests advisable during long-term ther

Dosage: Individualize for maxim beneficial effect. *Adults*: Tension, anx and psychoneurotic states, 2 to 10 m b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d or q.i.d. in first 24 hours, then 5 mg t or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i or q.i.d.; adjunctively in convulsive di orders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use und 6 months).

Supplied: Valium® (diazepam)

HARVARD MEDICAL ALUMNI BULLETIN

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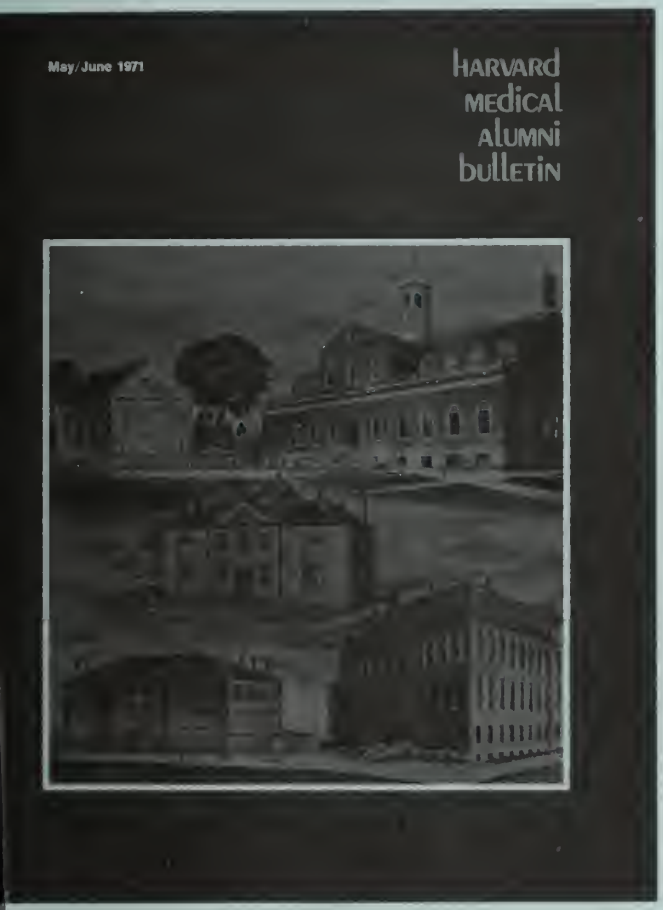
HARVARD MEDICINE VIEWS THE DRUG SCENE

Jan./Feb. 1973


The negative power of clinically significant anxiety
in angina pectoris...
This man feels he is living
on borrowed time.

Would you like to contribute
your share of the cost of the

HARVARD MEDICAL ALUMNI BULLETIN?



The total operating cost of the Alumni Bulletin is $60,000 annually. It is sent, without charge, to 6,000 Alumni and students.

Notes for the Bulletin

NAME: CLASS:

During anginal attacks, patients may suffer intense apprehension. More frequently, however, they experience a continuing sense of less severe but nonetheless disproportionate anxiety.

Reduction of such clinically significant anxiety is important, since undue emotional stress may precipitate further anginal episodes.

Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study,* Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)

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The positive power of adjunctive Librium® (chlordiazepoxide HCl)

10-mg, 25-mg capsules up to 100 mg daily

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

A copy of the Levine study may be obtained from your Roche representative.

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HARVARD MEDICAL ALUMNI BULLETIN
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COVER: Oil painting by Arnold Clapman entitled, "Junkie 1" captures the agony of the drug addict.

CREDITS: Cover, painting by Arnold Clapman, courtesy of Mr. and Mrs. Max Hall. Drawings, pp. 8-24, also by Clapman. Fabian Bachrach, p. 5.

The opinions of contributors to the Bulletin *do not necessarily reflect those of the Editorial Staff.*

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OVERVIEW

Council Deliberates Alumni Issues

This report appears at this late date because the deadline for submission of copy for the November-December issue of the *Alumni Bulletin* had passed when the typed transcript of the Council meetings became available.

The Council met on October 6 and 7, 1972. Those present were John H. Talbot '28, President; Claude E. Welch '32, President-Elect; Maxwell Finland '26, Past-President; James H. Jackson '43A, Vice President; Carl W. Walter '32, Treasurer; Perry J. Culver '41, Director of Alumni Relations; and George S. Richardson '46, Editor of the *Harvard Medical Alumni Bulletin.*

Councillors in attendance included: W. Gerald Austin '55, Roman DeSanctis '55, Samuel L. Katz '52, John W. Littlefield '47, John W. Singleton '57, and William W. Southmayd '68.

Absent were: Franz J. Inglefinger '36, Secretary, and Councillors Daniel D. Federman '53, John W. Kirklin '42, and Jesse E. Thompson '43A. Gordon A. Donaldson '35, Representative to Associate Harvard Alumni was meeting with the A.H.A. at this same time and could not be at the Council meeting.

Others present and participating in the discussions include Robert H. Ebert, Dean; Henry C. Meadow, Associate Dean; Miss Beverly Bennett, Assistant Dean for Resources; Mr. Joseph C. Donnelly, Director of Development; Miss Joan F. Rafter, Managing Editor of the *Bulletin;* and Stephen E. Goldfinger, Acting Associate Dean for Continuing Education.

The fall meeting of the Council occurred in conjunction with meetings of the Alumni Councils of other Faculties of Harvard University and Directors of the Associate Harvard Alumni. A plenary session for all was devoted to the development of continuing education programs for Alumni throughout the various faculties. By way of historic interest, this is the centennial year for continuing education at the Harvard Medical School, a program which was initiated as courses for graduates in 1872.

Discussions at the business meetings of the Harvard Medical Alumni Council were wide-ranging, vigorous, critical, and constructive. Some of the more important topics will now be briefly summarized.

Dr. George Richardson, in reporting on the *Bulletin,* stated that sofar, in response to the first solicitation for tax-deductible voluntary contributions, $1,580 or less than 3% of the budget for the *Bulletin* had been received. This was an encouraging beginning but 158 contributors from over 6,000 alumni seemed rather small. Solicitations will be made twice a year via an insert in the *Bulletin.* It was suggested that a study be made to see if there were some among the contributors to the *Bulletin* who had not given to the Harvard Medical Alumni Fund.

Final results of Annual Giving by Alumni for 1971-72 were discussed briefly. The total $319,011.12 compares very favorably with the amounts contributed in previous years; but this was given by 3,122 of 6,472 Alumni or a participation of only 48%. In the decade from 1959 to 1968, participation in Alumni giving ranged between 62% to 70%. Since 1969, it has fallen off to 51% - 54% and now 48%. A number of suggestions were made to explain this trend.

Student activism, along with the demonstrations and disruptions since the spring of 1968 have alienated a number of alumni at most universities. This has been a definite factor, but how significant is not known for the Harvard Medical Alumni.

Another fairly specific reason for lessened participation could be the fact that with ever increasing costs of a medical education, the number of graduates having a loan indebtedness has increased from ⅓ to ⅔ of the class during the last 10 years; and the size of the individual debt has more than tripled. A sampling of opinion among recent graduates has brought out a feeling of resentment at receiving an appeal for annual giving to the Medical School when they are also receiving regular notices of payments due on their loans. At the same time, some of those who had completed repayment of their loans felt a sense of gratitude and were ready to make contributions.

Analysis of the great variation in percentage participation among the classes suggested that vigor and effectiveness of the class agents is an important factor in participation. The Council suggested that there be a committee to study what were the reasons for those who stopped giving; what factors affected the attitudes of younger alumni toward the school; and how to develop more effective class agents and solicitations.

Speculation about reasons for the changing attitudes of the current medical students and recent graduates lead to a long and free-wheeling discussion about the curriculum, student life, and changing values. A number of possibilities were explored. Dean Ebert reported that he had just had a meeting with some of

the students from the Student-Faculty Committee and they too were much concerned about loyalty to the class and lack of interest in the non-academic activities of the class. The president of the fourth year class had arranged beer parties and outings but had very poor attendance at these functions. A small committee of the fourth year class has tried to produce the 1973 Aesculapiad but has given up because of lack of interest for a yearbook by the majority. Expressions of much greater feelings of loyalty to one's college than to the Medical School seems commonplace.

Among reasons for these changes in the students may be the greater heterogeneity of backgrounds and interests of medical students nowadays as more minority group students and females are admitted to the School. The medical school class is no longer a homogeneous, all-male "club." The present curriculum provides for only three semesters of all-class meetings. After the middle of the second year, students go their separate way and may never see some of their classmates again. With this type of curriculum, it is impossible for those 30 to 35 students who transferred into the third year to even become an integral part of any class spirit, if there is any.

A considerably larger student body has made it impossible for most of the single students to live in Vanderbilt Hall, which used to be the spawning bed for close and lifelong friendships among the majority of the class. Now pressures for room in Vanderbilt has resulted in a policy of priority for female and first year students. All others, including the increasing number of married students, find apartments or rooms scattered widely throughout greater Boston. Thus living arrangements impede the development of social cohesiveness of a medical school class. One hopeful note was the report of Mr. Meadow that there are plans for the construction of housing near the medical school which will make many apartments available for HMS students.

In planning for the election of officers and councilors for next year, there was considerable discussion about ways to avoid a self-perpetuating council. In order to increase diversity among both the members of the nominating committee and candidates for office, recommendations for names have been solicited from alumni in all parts of the country. When regional alumni groups become better organized, they will become a source of potential candidates.

Appointed by President Talbot to the Committee of Five to recommend nominees for councilors were;

W. Gerald Austin '55, Chairman
David E. Kopans '38
Hugo D. Smith '47
Eleanor G. Shore '55
Joseph L. Dorsey '64

For the Committee of three to nominate officers were:

Maxwell Finland '26, Chairman
John A. Schilling '41
John C. Nemiah '43B

Dr. Stephen E. Goldfinger presented an excellent and critical review of continuing education activities now sponsored by the Harvard Medical School. Approximately 40 courses, lasting from one day to one month are attended yearly by some 3,000 students from all over the world. In addition to courses, during the last 5 years, there has been developed an innovative program involving 7 local community hospitals whereby the educational content of the teaching effort was based upon assessment of the specific educational needs of the physicians in a particular hospital by review of records and cases. Such patient care audit has resulted in continuing education that is much more relevant and interesting to the hospital staff.

Dr. Goldfinger also emphasized the importance of evaluation of continuing education by review of its impact upon improvement in patient care and the habits of practice of physicians. This form of evaluation was much more indicative of success than measurements of attendance, applause, tuition fees or results of before and after student examination.

Following the presentation, the Alumni Council addressed itself to the question of what the Faculty of the Harvard Medical School or the Alumni Association might do to provide unique continuing education opportunities for alumni. The most negative point of view was that there already are too many continuing education courses available to all physicians so why do anything. Another thought was to take some courses to regional groups of alumni using local alumni experts together with some of the faculty from the Medical School. Concern was expressed about a possible suggestion of arrogance that might be engendered by this technique; but some councillors favored trying it.

At the plenary session of all Alumni Councils, one speaker told of the exciting and productive results of bringing alumni of varying ages back into the classroom with undergraduate students. As a result of this report, the Medical Alumni Council discussed the possibility of having a small number of alumni come back to participate with the medical students in selected courses, such as units of pathophysiology.

After further prolonged discussion of other possibilities, the Council arrived at a consensus that an effort should be made to develop a multidisciplinary symposium about some broad topic such as infection or immunology. This would involve both the basic science departments and the various specialties at the teaching hospitals. Such a symposium might be held in conjunction with Alumni Day. Plans for this will be reported later.

A list of other items considered by the council included:

A placement service for alumni; a regular program of visitation by medical students to the homes and practices of alumni; the possibility of elective preceptorships under alumni for medical students; and the need to develop a network of corresponding secretaries to increase and improve alumni notes for the *Bulletin*.

PERRY J. CULVER '41

Isselbacher Awarded Mallinckrodt Chair

Kurt J. Isselbacher '50 has been named the Mallinckrodt Professor of Medicine at Harvard Medical School. Dr. Isselbacher is chief of the gastrointestinal unit at Massachusetts General Hospital and chairman of the executive committee of the departments of medicine at HMS.

An outstanding clinical investigator in the field of gastroenterology, Dr. Isselbacher is held in high regard for his major contributions in the areas of basic science and clinical medicine. His scientific contributions primarily have been concerned with metabolic problems and vital physiologic processes involving the liver and intestinal tract. In the mid-1960's, he and his associates described a hitherto unrecognized genetic disorder of amino acid metabolism, isovaleric acidemia, which results in mental retardation and episodes of coma. He has also clarified the biochemical steps in intestinal fat absorption and has demonstrated the role of proteins and protein synthesis in the transport of lipids by the inner lining of the intestines. While at the NIH (1953-56), Dr. Isselbacher, with Dr. Herman Kalckar, now professor of medicine at HMS, was the first to recognize and describe the defect in the hereditary disease, galactosemia, and developed a specific enzymatic test for diagnosing the disease at birth before any mental retardation occurs.

As a teacher at the graduate as well as the postgraduate level at HMS, Dr. Isselbacher is in charge of the second-year course in gastrointestinal pathophysiology and has been active in the teaching of an elective course on the biology and biochemistry of disease for third and fourth-year students. He is also in charge of the gastrointestinal section of the postgraduate course in internal medicine given annually at the MGH under the auspices of the department of continuing education at HMS.

The Mallinckrodt Chair is one of several established by the University

Dr. Isselbacher

honoring the late Edward Mallinckrodt, Jr., a St. Louis manufacturing chemist. Mr. Mallinckrodt, who died in 1967, was an active Harvard alumnus and one of the great benefactors of the University.

Dr. Isselbacher's professorship is the second Mallinckrodt Chair to be established in the Faculty of Medicine. In January 1969, David G. Freiman, M.D., was named the Mallinckrodt Professor of Pathology.

OHMO Grant Saves HCSP

The largest grant in the history of the Harvard University Summer School has been received from the Office of Health Manpower Opportunity (OHMO), Department of Health, Education and Welfare.

The $1,135,000 three-year grant will support the Health Career Services Program, which gives minority group students premedical training and career counseling in the health professions. (See HMAB, Sept.-Oct., 1972) The grant, $371,089 in its first year, provides the funds needed to support 150 students for each of the next three years.

OHMO also gave partial support to the program in 1972 with a contract grant of $100,000.

Only 5.7 percent of medical school students throughout the country last year were members of minority groups. In a letter thanking OHMO for the grant, program director Thomas Crooks said, "If minority groups are not now given special support, the percentage of their involvement in the health care professions will drop even more over the next generation."

HMS To Introduce New Grade System

A four-point grading system, independent of letter grades, will be introduced at HMS this fall. The new evaluation scales supplant a "Satisfactory-Incomplete" grading system that has been in effect since September, 1970. The new system will affect only first year medical and dental students at the outset, and will not affect any students currently enrolled in the Medical School or School of Dental Medicine.

As formally adopted by the Faculty of Medicine at its December meeting, student evaluations will be recorded in one of the following categories; excellent, satisfactory, marginal, and unsatisfactory. It was also voted that marginal and unsatisfactory ratings could be removed from a student's record by fulfillment of remedial programs acceptable to the Promotion Board of the Faculty of Medicine. Additional evaluation, in the form of a written statement by individual instructors, also is encouraged.

Continued confidentiality of students' records is assured under the new system. The evaluations, recorded in the Registrar's Office, will be made available to the student, his tutor, the Promotion Board and to members of the Faculty concerned with necessary subsequent evaluation. The records will be made available to others only on the specific request of the student.

Multiple Bridges Needed to Upgrade Nation's Health

Neglect of social and environmental factors by academic health centers is partly responsible for the unsatisfactory state of the nation's health, according to Howard H. Hiatt '48, dean of the Harvard School of Public Health.

Speaking at the annual meeting of the Association of American Medical Colleges, Dr. Hiatt called for "multiple bridges" between the health sciences and a variety of other groups in universities, and challenged academic medical scientists and educators to recognize their own inability to solve some of the most crucial health problems in America today without the help of the best scholars in such non-medical fields as law, economics, business administration, and engineering.

Dr. Hiatt backed up his emphasis on the importance of non-medical factors in the total health picture by reporting the replies of medical school professors whom he asked to list the "most pressing unsolved health problems now confronting academic health institutions and society." Although all of those questioned are engaged in research on categorical disease or fundamental biologic phenomena, their answers revealed awareness that much broader problems must be attacked. Their health priorities are:

mental disorders, both their etiology and management;
the behavioral aspects of health maintenance such as tobacco, diet, alcohol, drugs, and accidents;
geriatric and other chronic illnesses;
population control, including quantitative and qualitative (genetic and environmental) aspects;
difficulties in access to health care; and
the effects of poverty and other environmental factors on health.

The list clearly suggests the great disparity between the problems listed as critical by leaders in American medicine, and the research problems commanding principal attention in the institutions with which they are associated.

One factor common to several problems on the list, Dr. Hiatt pointed out, is that little information exists concerning their underlying biologic bases. It is equally clear, he continued, that significant progress cannot await understanding of biologic basis. "One of our major mistakes in recent decades has been to assume that our responsibilities began and ended with biologic research and its application to individual patients. It was (and is) unreasonable to expect that health professionals, as they have been educated in the past, could apply the breadth of expertise required by complex health problems. On the other hand, with rare exceptions, members of other disciplines were not in a position to take leadership in applying their knowledge to the health fields. The neglect that has resulted explains in part our current difficulties in the health sphere."

Are these problems properly within the realm of an academic health center?

Most definitely, according to Dr. Hiatt, however, if the center should decide otherwise, he believes its minimal obligation is to insure that some groups within society do regard these problems as within their bailiwick.

Plans for an attack on the problems, he said, should include input from a wide variety of disciplines — economics, public policy, sociology, business management, statistics, decision theory, education, engineering, law, and ethics.

In approaching the health problems, Dr. Hiatt stressed that academic health centers must also turn to the community as a place to carry out patient care research, not that the center should take on major service functions, but its role should include the creation of new institutional mechanisms whereby the intellectual strength of the university might be made available to federal, state, and local governments. Another important objective is a public education program designed to assure an ongoing dialogue between the faculties of the center on the one hand, and society and its elected representatives on the other.

"We have seen major achievements in medical research in recent years. The deficiencies have been largely of omission: the absence of any overall health research policy; inadequate evaluation of the benefits and costs of clinical procedures; failure to appreciate and communicate to society the effects of social factors on health; reluctance to become involved in patient care research and in development. A key question," he re-emphasized, "is not whether, but how, the academic health center can take on these responsibilities without neglecting its continuing critical role in biologic investigations."

Alumnus Reviews Mitral Stenosis

Harvard alumnus, Richard A. Carleton '55, professor of medicine at the University of California, San Diego, and director of cardiology, San Diego Veterans Administration Hospital, was recently chosen the eighth Lawrence B. Ellis Lecturer in the Harvard Medical Unit at the Boston City Hospital.

The Ellis Lectureship was established by students, associates, and friends of Laurence B. Ellis '26 in recognition of his many contributions to cardiovascular medicine. Dr. Ellis holds the position of clinical professor of medicine, emeritus, at HMS.

Dr. Carleton began his lecture on "Pathophysiologic Derangements of Mitral Stenosis" with the question: "What is the mechanism of the deleterious role of atrial fibrillation in mitral stenosis?" A series of patients with mitral stenosis and

atrial fibrillation were studied after cardioversion. In the group as a whole, heart rate decreased, but there were no significant changes in cardiac output either at rest or during exercise. When the group was subdivided according to initial heart rate, however, it became evident that cardiac output in patients with heart rates greater than 100 increased after cardioversion, both at rest and during exercise.

Next, Dr. Carleton presented an elegant series of studies showing that normal atrial contraction played a minor role in compensating for left ventricular inflow obstruction.

The role of heart rate as a limiting factor in the circulation of patients with mitral stenosis was then studied. Dr. Carleton concluded that tachycardia was more deleterious to the patient with mitral stenosis than atrial fibrillation.

Tachycardia, however, did not explain all disability. Thus, Dr. Carleton initiated a search for a myocardial factor originally proposed by Fleming, and concluded that abnormal left ventricular function must be added to left ventricular inflow obstruction as a cardinal feature of mitral stenosis, and may account for some failures of surgical treatment and postoperative complications.

PROMOTIONS AND APPOINTMENTS

PROFESSOR

Aldo Castaneda: surgery
Daniel D. Federman '53: medicine
Roger T. Kelleher: psychobiology in the department of psychiatry at New England Regional Primate Research Center
Janet W. McArthur: obstetrics and gynecology at Massachusetts General Hospital
Hugo W. Moser: neurology at MGH
Morris Simon: radiology at Beth Israel Hospital
Morton N. Swartz '47: medicine
Austin L. Vickery: pathology at MGH

ASSOCIATE PROFESSOR

David W. Allen '54: medicine
Thomas L. Benjamin: pathology
Herbert Benson '61: medicine
Michael A. Bratt: microbiology and molecular genetics
Nina S. Braunwald: surgery at Peter Bent Brigham Hospital
John J. Collins, Jr.: surgery at PBBH
I. John Davies: obstetrics and gynecology at Boston Hospital for Women
Pierce Gardner '61: medicine at BIH
Irma P. Gigli: dermatology
Aaron Lazare: psychiatry at MGH
Frederick Naftolin: obstetrics and gynecology
Michael N. Oxman '63: microbiology and molecular genetics
Carl W. Pierce: pathology
Daniel C. Shannon: pediatrics at MGH
Richard C. Talamo: pediatrics
Alfred L. Weber: radiology at MGH

ASSOCIATE CLINICAL PROFESSOR

Lloyd E. Hawes '37: radiology
Thomas C. Peebles '51: pediatrics
Carter R. Rowe '33: orthopedic surgery
Roe Wells: medicine

ASSISTANT PROFESSOR

Americo A. Abbruzzese: medicine at PBBH
Anthony R. Bellve: physiology
Robert S. Brown: medicine
David M. Bull: medicine
Charles W. Cummings: otolaryngology at Massachusetts Eye and Ear Infirmary
Jeffrey A. Gottlieb '66: medicine
Lewis Landsberg: medicine
Barry W. Levine '65: medicine at MGH
James C. McFarland: medicine at Cambridge Hospital
Hugh B. McNamee: psychiatry at Boston City Hospital
David Miller: ophthalmology at BIH
John A. Parrish: dermatology
Alberto Ramirez: medicine at BCH
Robert R. Rando: pharmacology
B. Dianne Moore Smith: physiology
Samuel Ward: biological chemistry
Harold A. Wilkinson: surgery at BIH

ASSISTANT CLINICAL PROFESSOR

William F. Beuscher: psychiatry
Robert E. Desautels '46: surgery
Emmanuel Deutsch: medicine
Angelo J. Eraklis '58: surgery
Charles A. Fager: surgery
H. Howard Goldstein: medicine
Bernard S. Levy: psychiatry
Robert H. Lofgren: otolaryngology
John D. MacArthur: surgery
Francis G. Wolfort: surgery

SENIOR ASSOCIATE

Sidney V. Reider: medicine

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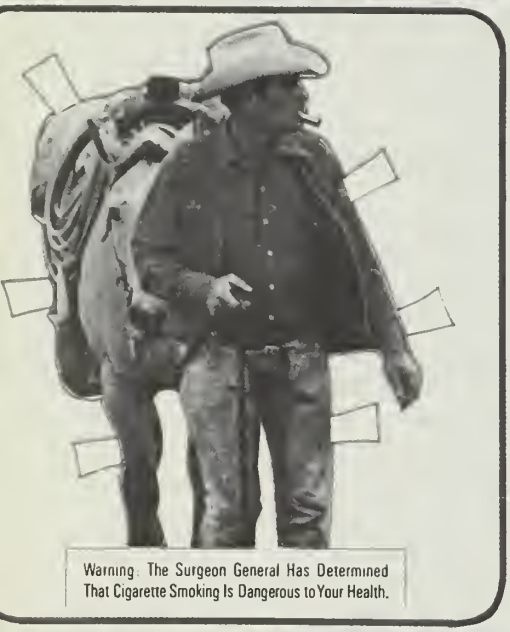


Harvard Medicine Views The Drug Scene

by Joan F. Rafter
Managing Editor

Do you think of "drug abuse" when you think of "What's wrong with America today?" If so, you will be interested to hear what Harvard Medical School alumni and faculty think about it, and what they are doing to ameliorate it. To learn about the problem, the *Bulletin* interviewed six people who are working in the field of addiction, to drugs and to alcohol, and this is their story.

The use and abuse of drugs, in general, is an emotionally-charged issue. More than any other drug, marihuana has been the victim of irrationality, and a considerable share of the blame for this, according to Lester Grinspoon '55, associate clinical professor of psychiatry and director of psychiatry (research) at Massachusetts Mental Health Center, can be laid at the AMA's door. Since 1945, they have clearly been biased, not only in their position papers and editorial statements, but also in the papers accepted for publication in the JAMA. Thus, they have done much to provide the quasi-scientific underpinnings for the myths that surround marihuana.

What are some of the myths? That marihuana is addicting; it leads to the use of hard drugs, sexual excess, violence, crime, anti-social behavior; its users are lazy and fall prey to an "amotivational syndrome." It seems to be futile to ask people to give up these myths when 81 percent of the nation agrees with President Nixon's TV statement that marihuana smoking leads to the use of hard drugs and 49 percent believe that marihuana is a more serious problem than heroin.

Where the myths originated is difficult to pinpoint, but Dr. Grinspoon suggests that they tend to be identified with the people who used marihuana in the early decades of the 20th century, when it first appeared from Mexico as the chopped pistillate and staminate tops and leaves of the Indian hemp plant. These were the Spanish-speaking and Black populations. The bigotry that existed then made it easy for people, perhaps through the unconscious process of displacement, to assign to marihuana some of the attributes it still lives with today. This type of bigotry is still a viable force in America, and is perhaps the reason people find it so difficult to forsake the myths, despite the growing dissemination of knowledge about the subject.

The recent Report of the National Commission on Marihuana and Drug Abuse has done much to demythologize marihuana. The Commission went so far as to conclude that marihuana is a relatively harmless substance; certainly less harmful than alcohol or cigarettes.

But for Dr. Grinspoon, the report did not go far enough. One of the things he criticizes is its insistence that the chronic heavy user is at risk. This is an unknown at this point in time. The Commission stated that their reason for not recommending legalization of marihuana is this concern for the heavy user, and the increase in heavy users that would result from legalization. Dr. Grinspoon points out that only two percent of those who use marihuana are heavy users. "This means," he said, "that

we are talking about 500,000 people, there being 24 million people who have tried marihuana in the U.S." Compare this figure to the 6-10 percent of alcohol users who become abusers. As to the validity of the Commission's assertion that there would be more heavy users if marihuana were legalized, Dr. Grinspoon argues that among those who do not now use marihuana primarily because its use is illegal, there are very few who would become marihuana abusers; and that the chronic heavy users are already a fairly well-defined population who have a need to abuse some psychoactive drug (even a more dangerous and truly addicting one like alcohol) and this need overrides any concern with legality.

The use of marihuana is growing. What we must consider is whether or not any of the psychopharmacological properties of the substance are as harmful to the users or society as the application of our present laws. Clearly, they are not. If the National Commission can agree that marihuana is not so harmful that it cannot be used in the privacy of one's home, why then should it not be sold publically? Dr. Grinspoon advocates legalization with tight controls. He envisions marihuana being sold at something like a state liquor store where dose level would be monitored at one to two percent of tetrahydrocannabinol. Thus legalization would cut down the adverse reactions that occurs when people buy marihuana of unknown potency and content on the street.

The current marihuana laws are totally out of proportion to the "crime" and serve to illustrate the failure of a prohibition policy. They also lead to a great disregard of the law.

A trend of de facto legalization is developing across the country, according to Dr. Grinspoon. In many cities, enlightened law enforcement people have come to realize that it is more important to prevent crime than to bust a bunch of kids smoking pot. However, Dr. Grinspoon is concerned that the laws against marihuana will remain on the books and could be applied capriciously.

What, then, can be done? Drug education over the past years has been abysmally poor. All drugs have been lumped together under one umbrella as equally dangerous. When youths see their friends smoking marihuana without any serious side effects, what can they think, but that they have been systematically lied to about all drugs? As a result, they are more likely to try other, truly dangerous drugs.

As long as there is a prohibition against marihuana, the drug educator has a difficult time being objective in presenting a realistic point of view. Most PTA's take a dim view of telling students the truth — that marihuana is less harmful than alcohol or cigarettes.

On the other side of the coin is drug miseducation and Dr. Grinspoon believes that TV and advertising have contributed to the total drug problem. He advocates no advertising of any drug whatsoever, including aspirin, Alka-Seltzer, and the like. "Advertising," he says, "has contributed immeasurably to the growing American ethos that we need tolerate no discomfort at all because there is always a chemical solution to our ills. We have exposed young, impressionable children to the idea that there is a pill for every problem, and it has had a pernicious effect on us all."

One thing that can be done is for the medical profession to take an active role in what Dr. Grinspoon considers one of the greatest medical problems of our time. Doctors have contributed to the problem and they must now better inform themselves because, as shapers of public opinion, they can help pave the way for more liberal and realistic legislation about marihuana, thereby removing it from the realms of emotionalism.

A SOMEWHAT different kind of emotionalism surrounds heroin, particularly in relation to the controversial area of methadone maintenance. Vernon D. Patch '58 is assistant professor of psychiatry at Boston City Hospital and director of clinical psychiatry at BCH. He is also the director of the City of Boston's Drug Treatment Program.

In April of 1970 the City allocated funds for the development of a drug treatment program, primarily for heroin addicts. The program consists of a methadone clinic at Boston City Hospital; an inpatient detoxification and day care unit at the Mattapan Chronic Disease Hospital; and methadone clinics in East Boston and Brighton. Each unit is well-staffed with a combination of professional and ex-addict counselors, nurses, and psychiatrists. Federal funding during the last six months has equalled Boston's investment in

drug treatment, bringing the total cost of this comprehensive program to $1.8 million yearly. New treatment units provided by federal funds include a drug clinic in Mattapan and a drug clinic in Boston's South End, and a rehabilitation workshop and day care program in North Dorchester. Additionally, a half-way house and sixth drug clinic are scheduled to open this month.

Why did the City of Boston become interested in the drug problem? Obviously the treatment needs of the City's heroin addicts were enormous and constituted the first motivation for developing a treatment program. A secondary motivation included the heroin addicts known involvement in crime and the possibility of crime reduction through effective rehabilitation. With an estimated 6-10,000 addicts in Boston, a significant reduction in addict-related crimes would provide benefits for the entire city.

Studies of the criminal activity of addicts yields interesting data. Dr. Patch and his associates have obtained, in a highly confidential way, access to probation records of nearly all of the 5,000 known addicts in Boston. These records are unique in Massachusetts in that any crime committed anywhere in the state leads to an entry on the probation record within 48 hours. Using these data, he was able to calculate the rate at which a substantial sample of addicts commit crimes in specific categories. Coupling this with information from the Federal Bureau of Investigation's Uniform Crime Report, he could then calculate the likely contribution of the City's small number of addicts to the total crime committed in Boston. Studying a sample of 500 addicts, Dr. Patch discovered that addicts commit 25 percent of the robberies, 33 percent of the burglaries, and 75 percent of the larcenies. The locale of the crime was then checked and it was learned that addicts commit 50 percent of their crimes within the City limits. Finally, Dr. Patch discovered a precise relation between violent crimes and crimes against property in the ratio of one violent crime for every 2.82 property crimes committed by addicts.

Methadone maintenance programs can reverse crime escalation. Methadone provides the most predictable outcome for the heroin addict, because in most cases, the addict can return to his family, to employment, to school, and can stay out of trouble with the law.

But the controversial nature of methadone is argued daily. Criticisms center on the fact that it is merely a substitute addiction, not a treatment. Dr. Patch prefers to call it a form of patient management, or a rehabilitative measure, admitting freely that it is not a cure. From data across the country, methadone maintenance is a successful rehabilitative technique compared to other "treatments" for the heroin addict.

Every treatment available today for heroin addiction has its limitations. Self-help programs, such as New York's Day Top Village suffer a 99 percent failure rate after ten years of operation. Chicago's Gateway House reports only eight percent of the patients still in treatment after 12 months in the therapeutic community which was established to provide an 18-month course of treatment. One self-help program in Boston recently held a graduation ceremony. The program has been in operation five years and had five graduates. The cost for each graduate was somewhere between $50-80,000.

Detoxification programs don't fare much better with a success rate of roughly three percent. Most participants return to their addiction in a short period of time. Ambulatory detoxification, for many patients, is like "drying out" an alcoholic.

One of the things Dr. Patch feels strongly about is that the addict should have options for treatment, and the program at BCH is multimodal. The addict can be detoxified on an outpatient basis using methadone over a three-week period, re-

ducing the dosage so that the patient suffers no painful physical or psychological withdrawal symptoms. Alternatively, he can enter the inpatient unit for three weeks. Both of these detoxification programs are coupled with psychiatric counseling.

Or, the addict can elect methadone maintenance. There are federal guidelines that the addict must meet if he is to enter the methadone program. He must be 18 years of age, have at least a two-year history of addiction, show evidence of failure in some other, reasonable treatment program, and be free of psychotic tendencies and serious physical illness.

All of the methadone maintenance clinics in Boston's Drug Treatment Program are open seven days a week and the addict must report daily for his dosage. Methadone is administered in combination with Tang and must be consumed in front of a registered nurse, thus totally eliminating the problem of diversion into the community.

Diversion is another of the criticisms leveled at methadone. In New York, for example, patients earn "take-home" privileges and the addict is given his dosage to take at home on the weekend, when the clinic is closed. It is not surprising, therefore, that methadone has found its way into the streets of the city, thus compounding the addiction problem.

The problem of diversion is only one of the reasons that Dr. Patch is opposed to the English system of heroin maintenance. Heroin effects have a duration of 4-6 hours and if heroin were to be used in maintenance clinics in the U.S., it would either have to be administered to the addict 4-6 times daily in the clinic, which would obviously create a logistical nightmare, or the addict would have to take pure heroin home. If heroin were to enter the streets of Boston, it would surely be cut and sold, resulting in an even greater problem of addiction.

A great deal of misunderstanding surrounds the British system, according to Dr. Patch. The number of addicts in England is approximately one-quarter the number of addicts in the City of Boston alone. Our problem is one of completely different magnitude. There is a take-home policy in Britain and data show that the number of addicts and criminal activity are on the rise. It is interesting to note that there are more addicts maintained on methadone than on heroin in England. "For the most part," says Dr. Patch, "heroin maintenance is used as a carrot to lure the addict into a treatment program. As quickly as possible, he is shifted to methadone, basically because of the pharmacology of the drug."

Questions of social control and genocide are often raised during discussions of methadone maintenance programs. There is a paranoia among some people that the White man will addict the Black man with methadone and then control his actions under threat of withholding methadone. Actually, Whites outnumber Blacks by two to one in the Boston drug program. And this kind of thinking sells the addict short because if methadone were used to control the patient in any way, there would be a parade of protesting addicts to City Hall or to the Mayor's Office of Human Rights.

What about genocide? Critics claim that methadone destroys sexual ability, resulting in no sex, no intercourse, no reproduction. Ergo, genocide. But all of Dr. Patch's patients tell him that they can perform sexually, and in all cases, do so even better than when they were on heroin.

The major reason for the infighting among various drug treatment modalities is the funding problem they all face. But Dr. Patch believes that heroin addiction must be looked at in terms of the chances for effective treatment and, within the spectrum, cost effectiveness must be considered. He would like to see more money for all the various modalities, including his own program of methadone maintenance in Boston's Drug Treatment Program, which he believes is getting the most out of the already scarce treatment dollar.

DR. Jack H. Mendelson is professor of psychiatry at HMS, and director of psychiatry at Boston City Hospital. He is studying a different addiction — alcoholism.

One of the major problems confronting those who work with alcohol-related problems is similar to one in the drug field — little is known about the factors that cause or perpetuate problem drinking, and the search for causal factors is labyrinthine. Dr. Mendelson believes it is probably impossible to isolate a single cause in terms of a prevention model and feels that once the problem drinker has been identified, the important thing is to look at a broad category of events to see what might be done to intervene successfully.

There are 25,000 admissions per year at Boston City Hospital; 3,000 of these are for alcohol-related problems. In answer to these statistics, BCH has developed a treatment program with three major components; inpatient, outpatient, and a half-way house. Therapy is traditional and eclectic, including counseling, psychotherapy, rehabilitative services, and a variety of social aids.

However, the Hospital does have some innovative treatment services. They have recently established a type of half-way house for women alcoholics and an Antabuse clinic with a novel feature. Rather than using a take-home policy, alcoholics come to the clinic for therapy and counseling. Dr. Mendelson and his associates are conducting a pilot experiment to determine if alcoholics will remain abstinent for specified periods of time if certain rewards and incentives are promised. One reward used as an adjunctive aid in alcohol-related problems is marihuana.

Among other investigative work being carried on by Dr. Mendelson is a study to determine why 400,000 of the 4.7 million problem drinkers in the U.S. develop liver disease. They have concluded that it is probably a genetically determined factor, connected to a derangement in lipoprotein metabolism. For the past several years, Dr. Mendelson has

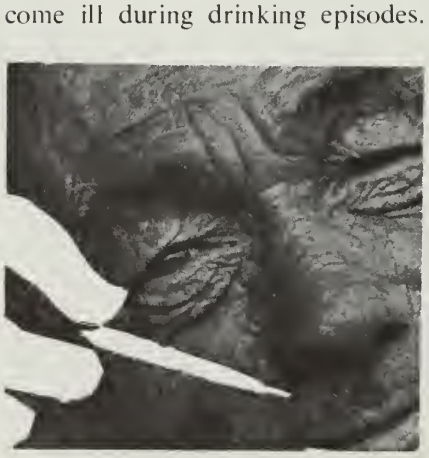
also been looking at the way alcoholics drink. What motivates them? What perpetuates drinking? What mood changes occur? What do they expect from their drinking episode? This area is generally referred to as the experimental analysis of alcohol acquisition and consumatory behavior, and Dr. Mendelson has borrowed techniques from behavioral and operant conditioning to aid his study.

Closely allied to this is his study of the biobehavioral concomitants of alcohol-induced aggressive behaviors. There is some indication that the people who are wracking up their cars on the thruway are probably alcohol addicts because their blood levels are not at the moderately high social drinking levels, they are roaringly high. So high, in fact, that if they were not addicts who had acquired a high tolerance, they would never have gotten out of the driveway, much less onto the freeway.

Everyone knows about alcohol-induced aggression; more than 50 percent of the arrests in the U.S. are for "drunk and disorderly behavior." But no one knows what causes it, and Dr. Mendelson is questioning whether neural factors might somehow mediate the aggression.

Recently, there has been an increasing amount of evidence that there may be a correlation between aggressive behavior and the metabolism and catabolism of androgen, specifically testosterone levels. Dr. Mendelson has been studying serum testosterone levels in alcohol addicts, who are felons or who have been involved in dangerous and destructive acts, and has discovered an interesting phenomenon. When an addict begins drinking, he produces a dramatic and remarkable suppression of testosterone levels. Dr. Mendelson admits that this should not have come as such a surprise considering that testicular atrophy and gynecomastia are often observed in elderly addicts. As blood alcohol levels begin to decrease, there is an interesting rebound effect; testosterone levels don't merely return to normal, but jump way over. Using aggression rating scales, it is at this time that obnoxious, obstreperous, fighting behavior is manifested. With some chagrin, Dr. Mendelson admits this should have been evident, too, because we all know the story of the man who went on a binge, returned home, and then displayed mean and nasty behavior.

Approaches to treatment of alcohol-related problems fall into two broad categories; minor tranquilizers to reduce anxiety and Antabuse to negate the pleasure of alcohol, which problem drinkers quickly learn not to take when they do not want to become ill during drinking episodes.



Dr. Mendelson and his colleagues are experimenting with a new form of treatment — the beta adrenergic blocking agents.

About four years ago, experiments showed that these agents inhibited the development of respiratory depression caused by alcohol and also seemed to shorten the sleeping time produced by alcohol administration. Was it possible that the beta adrenergic blocking agents and alcohol were hitting the same target in the brain?

More recently, studies on familial action tremor at the Massachusetts General Hospital revealed that beta adrenergic blocking agents caused the tremor to disappear. Prior to this discovery, the classic treatment for familial action tremor had been alcohol. However, as more and more alcohol was needed to quiet the tremor, the patient often became an alcohol addict.

These two separate studies caused the BCH researchers to wonder if ethanol and the beta adrenergic blocking agent, propanolol, might favorably affect the same neurological condition. Might the receptor site in the CNS be identical? On this basis, they initiated a double-blind study on the effect of low dosage propanolol and placebo on low dosage acute alcoholic administration. Using measures of mood and psychomotor function, they have found that propanolol does indeed block a number of the effects of alcohol. With propanolol, the individual feels sleepy, no aggressive induction takes place, there is no high; simply stated, the individual feels

nothing at all. If a long-acting blocking agent can be found, it would be a very useful tool for people trying to control problem drinking.

THERE is a possibility that blocking agents might be useful therapeutic tools in heroin addiction as well, according to Roger E. Meyer '62, associate professor of psychiatry, director of the Boston Center for Biobehavioral Studies in the Addictions and director of inpatient services (psychiatry service) at Boston City Hospital.

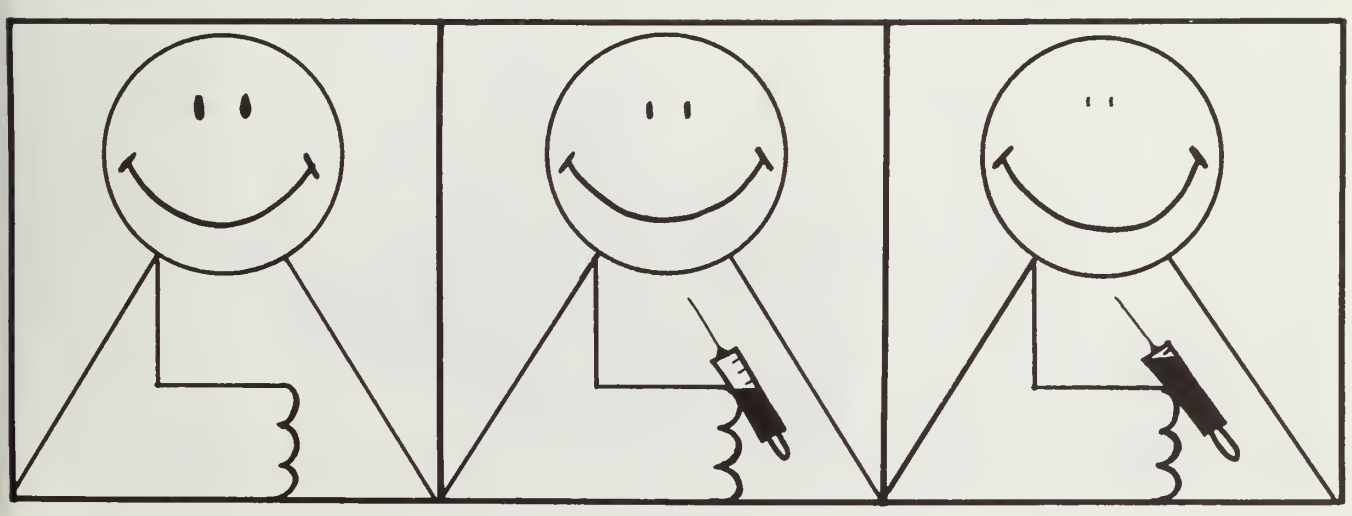
By using the heroin blocking agents, in this case, naloxone and naltrexone or cyclazazine, Dr. Meyer hopes to be able to document the principles of extinction that apply to drug addiction, specifically that extinction can be encouraged if the patient has been blocked from feeling the effects of heroin. The theory of extinction is an interesting one. It argues that the patient, attempting to readdict himself and failing to experience reinforcement, would attempt to increase the rate at which he would try to readdict himself, and, continuing to fail, would eventually stop trying. The theory works in animals, although it would clearly be more complicated in man. Dr. Meyer sees the goal of the blocking agents in much the same light as Dr. Mendelson sees the alcohol blocking agents — as a useful crutch for addicts over critical periods in their lives.

While methadone maintenance treatment currently involves 6,000 patients in treatment, the narcotic antagonists are clearly experimental. There are, however, certain populations for whom these agents might represent an important treatment. Hard core heroin addicts who have been socially rehabilitated on methadone may opt to discontinue methadone and lead drug-free lives. Psychologically, some of these addicts may require further treatment (for one year) on narcotic blocking agents in order to promote extinction of all opiate seeking behavior. Addicted adolescents currently pose a special problem because physicians are reluctant to place them on methadone maintenance, substituting one addiction for another. The blocking agents would allow adolescents to be drug free during their period of rehabilitation.

Narcotic antagonists have also been advocated in more controversial areas. It has been proposed that high school students be screened for drugs of abuse. When morphine-positive urines are found, students would be required to enter narcotic antagonist treatment. Dr. Meyer believes this could cause all students using drugs to leave school in order to avoid urine testing. Alternatively, the students would seek out other drugs (non-opiates) if the program was limited to the "vaccination" approach to drug prevention. Another related area, employing the "magic bullet" approach to drug addiction, offers injections of narcotic antagonists to people entering "high-risk" areas to drug addiction.

Opiate addiction is the end point of a complex and continuing interaction of biological, psychological, and sociological variables. In the past, we have concentrated on psychodynamic and/or sociological formulations which generated interesting associations while providing little understanding of etiology and/or the treatment process. The availability of animal models of addiction, and the opportunity to study two different psychopharmacological approaches to the modification of opiate seeking behavior in man make this area unique (at this time) for biobehavioral and clinical research investigation. Colleagues in epidemiology and public health are finding supportive evidence that heroin epidemics follow the pattern of spread associated with contagious diseases. The opportunity to decipher this complex problem with research tools utilized in other disciplines makes one optimistic about eventual long-term understanding of the problem.

TRYING to get such an understanding is the goal of Dr. Norman Zinberg, assistant clinical professor of psychiatry. His major concern is the natural history of drug taking and the importance of set and setting. He is particularly interested in what he calls his "chipper study." Chippers



are people who use drugs occasionally. The chipper is in the middle — he can be pushed into abstinence, regular use, or he can make chipping a stable pattern.

The paradigm for the chipper study is alcohol use in the 18th century, when people were either abstemious or drunkards. Over the past two centuries, we have gradually developed a socialization process for alcohol which has also been an attenuation process, so that most people who use the drug, don't abuse it. This process had nothing to do with law or legality for obviously the law never stopped anyone from becoming an alcoholic. Society developed the necessary rituals, mores, values, and standards, so that drinking is today a socially acceptable past-time.

Dr. Zinberg reminds us that drug use is not a new phenomenon. Cab Calloway recorded *Reefer Man* in 1928; Havelock Ellis took mescaline and peyote in 1898, wrote about it and caused a flurry of activity, which quickly died down. What was it that caused drugs to "catch on" in the early 1960's?

Obviously, suggests Dr. Zinberg, there were myriad social factors involved. We were emerging from the complicated period of the 1950's, and we were beginning to be interested in concepts of social justice and equality. For the first time, we recognized that our educational system was deficient because we were educating people in the past. We were still stressing the problem of insufficient goods and the need for each person to fight for what he thought was necessary for survival. At the same time, we were trying to inculcate a spirit of philanthropy and generosity.

As we began to shift to a society where we had sufficient production, we were faced with problems of distribution, and the problems of equality took on an entirely different tone. Our educational system was geared toward educating people to produce more, and was not concerned with the basic problem of distribution. The result was an intrinsic dissatisfaction on the part of the population being educated.

These were the social factors involved. "But," says Dr. Zinberg, "I was not content to lay the blame on these alone, and began to look to a more intrinsic personality issue." He finally decided that television was at fault, not in terms of program content, but on the basis that each time there has been a powerful technological innovation, an unanticipated social change has resulted.

Although the still was invented in Italy in the late 15th century, alcoholism did not appear until the beginning of the 18th century when fertilizer was developed and, for the first time in history, there was an excess of grain production. Alcohol was suddenly available, and on its heels, the unanticipated result — alholism.

Dr. Zinberg argues the case against television as follows: he believes that the printed word puts a great demand on people. To learn words, phrases, sentences, and paragraphs, it is necessary to inhibit diffuse emotions and vague sensory impressions, and work within prescribed, clearly-defined psychic boundaries.

Television, on the other hand, makes fewer demands — it emphasizes the viewer. Because detail is necessarily lacking, the viewer is encouraged to join with the set in supplying what is missing, thereby allowing flexibility to psychic boundaries.

If you have a culture whose chief problem is the inhibition of emotionalism and sensory perception, then that culture will seek a drug which can minimize inhibition and eliminate the feeling of being in a psychic cage — alcohol.

If, however, you have a culture concerned with differentiating boundaries, which is the point to which television has brought us, then that culture will seek a drug more concerned with boundaries — marihuana and psychoactive drugs, which are concerned with being "in" something.

The difference between the use of alcohol in the 18th century and the use of marihuana in the 20th is that the use of alcohol has been acculturated, while that of marihuana has not. The result — predicted by Dr. Zinberg eight years ago — is an enormous dissonance that is pushing people deeper and deeper into a war of culture and counter-culture.

Today, Dr. Zinberg believes that the leading aspect of the issue is the result of culture vs. counter culture. The attitude of the general public is excessive, irrational, and filled with myths, misconceptions, and fantasies. This hysterical, overemotional attitude fuels the laws while the laws fuel it, thus preventing good research and a sober assessment of what is really happening. Dr. Zinberg fears that drug use has become the vehicle of a great deal of social preoccupation with law and order. People have come to believe not that there is too much law and order, but that there is too little.

There is a strong movement today to use the heroin issue as an entering wedge for the introduction of a number of treatment possibilities, such as preventive detention and involuntary civil commitment. Both these treatments, however, depend on early detection, by means of a compulsory urine testing program for example. Since this could not possibly be a nation-wide endeavor, public health officials would begin their program in high risk areas. Another stigma would be imposed upon the ghetto, and what Dr. Zinberg regards as a pernicious civil liberties problem.

MORE realistic preventive approaches are the major preoccupation of David C. Lewis '61, assistant professor of medicine at the Beth Israel Hospital. Such approaches are extremely difficult to delineate because we lack the basic information about the lifestyle of drug users; we don't know what marks the transition between abstinence and experimentation, experimentation and addiction. The major factors that lead to destructive drug use still elude us. There is glib talk about curiosity and peer pressure as the cause, but we are unable to define these processes because we do not understand the drug addiction process itself. People still talk about drugs as if they are all the same and mean the same thing to young people, although we know that personality, the nature of the drug, the route of administration and the social influences that bear on the individual's decision to experiment are critical. We have tended to oversimplify by calling drug use, drug abuse. This denies the possibility of patterns of behavior in the use of drugs that are not necessarily destructive.

The drug problem can be viewed from the point of view of disease or health. Viewing it as disease: what is there about the personality and social features of life that lead to an addictive pattern or destructive behavior related to drug usage? And from the point of view of health: what contributes to the health of the community, and what prevents destructive tendencies in individuals? To understand the problem, both aspects must be examined because personality, social factors, and pharmacology are all important determinants.

Dr. Lewis is the first to admit that there is no solution to the problem of drug use, but there are approaches. He agrees with Dr. Zinberg that present proposals for early detection and prevention might quickly lead to civil injustice. His approach, therefore, is educational.

Realizing that no single drug program will solve the dilemma, he has designed material for elementary, junior high, and high school students. "The most we can hope for from these drug education programs," he says, "is that they may make risk taking and decision making more understandable to the individual."

The elementary program is an audiotape in which four elementary school children from different parts of the U.S. with varied backgrounds describe their lives, friends, and neighborhoods. Drug use, drug abuse, and addiction is only described to the extent that it enters their lives and perceptions. A video component is added to allow the children to see as well as hear the other students.

The junior high school program includes a series of audiotaped interviews with drug experienced youth. It contains some information regarding drugs, and some case studies intended to stimulate class discussion about the decision making process that leads to drug use and drug abuse. The presentations are in no way glamorized, but are offered in a realistic social context, so that students do not feel that it is a risque subject. The audiotape generally elicits a spontaneous class discussion that is lively, but quickly leaves the subject of drugs and goes into family relationships, the relation of youth to authority, the quality of life in the community, recreational activities, and the way people get along together. This is precisely what Dr. Lewis hoped the program would do.

The high school program is an educational television presentation, and involves problem solving in a community in which heroin use has just begun. Students are asked to design programs, thereby revealing their attitudes to the addict, and what addiction means to them. One group developed a plan of approach to heroin addiction which was taken to Senator Harold Hughes. Dr. Lewis then interviewed the Senator who commented candidly on what he thought would work and what he thought would not. These comments were then presented to the students who thus felt that they were effectively participating in one of the serious problems of the day.

Part of the difficulty in putting the drug problem into any kind of rational perspective, according to Dr. Lewis, is the confused rhetoric that surrounds the issue. This, in turn, mirrors great gaps in our understanding. Education is only one way to change this. Research is another, and Dr. Lewis strongly advocates that much more funding be made available, because it is through research that better understanding will come. And with better understanding, the problem of drugs will hopefully be viewed rationally, and with intelligence, by all.

The Treatment Game

by Houston Johnson, Jr. '75

HEROIN abuse presents one of the biggest challenges to the area of community medicine. In many respects it is a frustrating challenge because it defies familiar preventive and curative models for disease controls. There are no simple inoculations that can be given to make people immune to heroin abuse or addiction, nor is there a specific drug therapy that can be evoked to permanently cure the desire for or ill effects of heroin abuse or addiction.

Heroin abuse also presents one of the biggest challenges to the struggle for community development. Here lurks the gruesome threat of its reaching pandemic proportions where it will vigorously militate against attempts and hopes of salvaging and cultivating resourceful young minds in poor communities. One may also add to this the current wasted talent among individuals who are now addicted to drugs, as well as the millions of dollars that are being channeled into treatment and custodial programs that could be better used in other areas, such as eliminating housing, education and vocational training problems.

Indubitably, there are many reasons why some people turn to heroin.

When heroin addiction was strictly a problem of low income communities, experts would confidently excuse its etiology as being due to a multitude of factors that accompany a background of poverty. However, now that the tentacles of heroin abuse have reached the protective environment of the middle class of America, the same experts scratch their heads displaying confusion and uncertainty.

Dr. P. Boyd, who has run therapeutic communities in England for adolescent heroin addicts, sums up well the psychological factors that can be found most frequently discussed in the literature as reasons why adolescents get involved with drugs. Dr. Boyd notes that: (1) Drugs provide an easy way of getting pleasure in a social setting, like alcohol does for adults; (2) Drugs allow adolescents to engage in something secret and special to themselves; (3) Drugs appeal to the magical thinking of adolescents and may carry them on a journey beyond the confines of the mind; (4) Drugs may offer a special challenge, like the game of chicken; (5) Drugs bolster an adolescent's identity at a time of uncertainty; (6) Drugs offer an avenue of escape when stress is overwhelming; (7) Drugs destroy something unwanted in the self. Boyd goes on to suggest that the first four reasons appear in all drug experimenters. However, when drugs become used for the last three reasons, dependence is likely to result.

I would like to add to the above list some observations of my own that may be a bit more ethnically specific: (1) In their peer groups and among adults, many youths see people they admire and wish to emulate involved with drugs. Their own involvement is then precipitated because they view dealing with dope as a "cool" thing to do. (2) Many young people overestimate their strength, believing they can safely experiment with anything because they are capable of exercising constraint if things begin to drift too far. When, either because of personal gratification or because they think they can handle some situations better when they are "high," they expand their use of drugs, they discover they are hooked and no longer have control of their lives. (3) People who are weak in terms of controlling their own lives often try to influence their friends to use drugs. (4) Misery likes company and will capitalize on gullibility.

Because we are unwilling to accept the mechanisms perpetuating heroin addiction and abuse as inventions of our society, many of us fail to think of it in the perspective of community dynamics. We tend to focus on the social symptoms of the problem, such as crime. Our thoughts build images of psychopathic individuals ripping off other people and property. In this context, we then cast about for conglomerate schemes to deal with these symptoms. As we do this, the heroin industry strides from one plateau of strength to the next.

Social symptom thinking now dominates the therapeutic approaches that exist, and in turn, makes a strong impact on what is going on politically in communities regarding therapy.

Vested interest groups have emerged in communities and are fighting over who should have priorities in determining the way the system should deal with "junkies." Dr. Arnold J. Mandel of the department of psychiatry at the University of California, San Diego, has carefully defined interest groups in the following way: (1) There is the Justice Establishment with its incarceration, parole, and probation treatment programs. These programs are designed "to appeal to the [anxieties] and righteous wrath" of the general population. Since many people believe this is the proper body to handle addicts, it clearly wants to keep addicts in its province; (2) There are self-help groups that are founded on the model of Alcoholics Anonymous, etc. These groups have flourished over the past few years, and now pose a particular challenge to psychiatry and existent social rehabilitation models. They focus on psychosocial adaptation for addicts using abstinence as their motif. Among

these groups, there is much rhetoric about the 'Mystique of the Dope Fiend,' the thesis being that only one addict is competent to understand and help another addict. These groups consistently berate the medical profession as incompetent. Obviously, they oppose pharmacological approaches to treating heroin addiction. The politics are avid in this area, because these programs have opened up new career opportunities for ex-addicts, and they are exceptionally keen on maintaining them; (3) One can find "local political activists" in on the act as well. Their primary interests seem to be controlling budgets and deciding policies regarding program admissions, hiring, etc. These groups often raise legitimate issues that underscore aspects of community development. Their aims, however, get easily interpreted as selfish rewards for a limited number of people; (4) The medical psychiatric establishment is getting involved because it wants to develop the area of community psychiatry. With the government footing the bill for so much medical care, psychiatry is being forced to adapt its treatment methods so they will be revelant to community needs. The government is not demanding that psychiatry develop meaningful treatment modalities for drug addiction. Instead, it is prepared to pour money into developing extant mental health systems that may be applicable to dope addiction.

Given the conservativeness, general lack of imagination and the desire to tap federal monies in the area of psychiatry, it should come as no surprise that this discipline is pushing methadone maintenance. Since 1966 when Drs. Vincent Dole and Marie Nyswander, working at the Morris J. Bernstein Institute of Beth Israel Medical Center in New York City, reported that they had successfully treated heroin addicts with methadone, the medical profession has increasingly been willing to accept it as the most effective therapy available. Neither should this be surprising since doctors are usually prepared to accept treatment modalitites pushed by the medical establishment. Furthermore, methadone maintenance "fits well into the traditional illness-treatment model," which thrives on management by dispensation of medication.

METHADONE was developed by German chemists to serve as a synthetic substitute for morphine during World War II. Many of Hitler's high ranking officials are reputed to have been notorious morphine addicts. When it was imminently clear that Germany would be defeated in North Africa where their poppy fields flourished, a directive went out to German scientists to come up with something quick. The response was methadone and was officially named Dolophine in honor of Adolf.

The research that established methadone as the medical therapeutic answer for heroin addiction began in 1965 and seems to have been based on the premise that heroin addiction is a metabolic disorder that can best be handled through drug therapy. To my knowledge, this was the second time that doctors had tried to make a psychosocial addictive problem a metabolic disorder. The first time was during the early 1900's when heroin was introduced as a cure for morphine addiction.

The metabolic basis for heroin addiction is probably a new concept for psychiatry that challenges the more widely held view that habituation is probably the single most important aspect of addictive states. There does not appear to be any compelling evidence to support the concept of metabolic lesions in heroin addicts dictating their addiction.

Some of the original work on methadone was done in Lexington, Ky., by Dr. Harris Isbell. By 1949, he had shown that methadone was a dangerously addictive drug that could be smoothly substituted for morphine in addicts. By gradual substitution, addicts were unable to tell morphine had been replaced. Dr. Isbell went on to show that when injected, addicts would come to prefer methadone over heroin and morphine. It may be inferred from these findings that in an addictive population, methadone may have a greater addictive potential than either heroin or morphine.

Seventeen years after Isbell's careful analysis of the effects and uses of methadone, Dole and Nyswander published a report about a new successful treatment of heroin addicts that blocked the orgasmic effects of heroin and obviated craving for heroin. The treatment involved the use of methadone. At this point, all of their claims for success rested on the known pharmacological addictive properties of methadone. So, by choosing these factors as a basis for success, they could not miss.

Since the government is now supporting methadone maintenance as a successful treatment for heroin addiction in communities, it is crucial that we examine the criteria of success it is using to determine whether methadone meets these.

Prior to 1969 when methadone maintenance programs began to sprout up in big cities across the country, the principal criterion of success in treating heroin addiction was attaining a drug-free state. However, since methadone maintenance does not allow this, and in fact maintains addicts in an addicted state, there had to be a redefinition of successful treatment.

The large methadone maintenance programs such as the ones in New York, Chicago, Philadelphia, etc., are now reporting successful treatment in terms of the percentage of

program participants employed legitimately and the infrequency of arrests that result in court proceedings among the program participants. Many smaller programs that cannot report favorable percentages are justifying their existence on the fact that most of their participants show up for their methadone.

If one relates to heroin addiction largely in terms of its social symptomatology, then high percentages of employment and decreased criminal activity are perhaps the best criteria to use in evaluating the success of methadone maintenance.

An analysis of methadone programs in terms of these criteria is reported by Drs. James F. Maddux and Charles L. Bowden in a recent issue of the *American Journal of Psychiatry*. They point out two major problems with statistics on criminal activity and employment coming from methadone maintenance programs: (1) They are not based on the initial addict populations that programs begin with, and (2) The comparison data is unequal and insufficient.

One can even find discrepancies in reports of crime reduction related to methadone. In August of last year, a spokesman for the State Department of Mental Health was quoted in the *Boston Globe* as saying that methadone maintenance had led to a reduction of crime in the city. In September, the *Globe* reported on an FBI study which indicated that robberies and aggravated assaults, two categories in which drug crimes are included, increased 20 percent and 15 percent, respectively, in Boston.

In other cities, where there was an average decrease in crime of 2 percent, surrounding suburban areas experienced a 5 percent increase in drug crime categories.

It is clear, at least to me, that there is no firm basis for saying that methadone maintenance is eliminating crime.

Maddux and Bowden went further to compare employment reports from methadone maintenance programs to those of drug-free programs. They found that in four published reports from drug-free programs, there was a median employment of 38 percent. This was compared to a median of 53 percent of seven methadone maintenance programs.

It should be added that only two of the methadone maintenance programs reported the employment rates of program participants at admission. It is important to know this information if the effectiveness of methadone maintenance programs in increasing employment of addicts is to be fairly judged.

It is not correct to assume that employment rates among addicts entering methadone maintenance programs are zero. One may or may not consider the 15 percentage point difference between methadone maintenance programs and drug-free programs significant. Even if it is considered significant, one cannot say that it represents the effects of methadone maintenance; neither can this difference be interpreted as a success rate of 70-90 percent.

Although Drs. Maddux's and Bowden's analysis is not definitive, it does focus on the shaky manner and unsound basis upon which data is now being reported from methadone maintenance programs. Their study also seriously raises questions as to whether statistics, reported to establish claims of success in reducing criminal activity and increasing employment, do in fact, show success. Instead, they conclude that reports are too ambiguous and exaggerated to be reliable.

A new problem communities face is that methadone is a killer. By October of last year, the Chief Medical Examiner in New York City reported that there had been 100 deaths due to acute methadone intoxification. This can be compared to a total of 13 deaths reported for the same cause in all of 1971. This increase in deaths from methadone accompanies a decline in deaths from other addictive drugs during the same period. From January to October of 1971, there had been 719 deaths reported due to addictive drugs. From January to October of last year, there had been 687.

If we subject the success of methadone maintenance programs, to a reasonably objective analysis, we find: (1) There had to be a redefinition of what successful treatment of heroin addiction is to institute methadone programs; (2) If criminal activity for addicts in methadone maintenance programs is studied over periods of time, equal to periods of addiction prior to their being admitted in programs, there may be no difference in the level of criminal activity; (3) If one could correct high employment rates reported by methadone maintenance programs for the rates of employment of addicts at the time of admission, there may be no appreciable differences in employment rates of addicts in methadone maintenance programs and those in well run drug-free programs, and (4) Methadone is turning out to be a new killer in communities.

This discourse offers a general assessment of heroin abuse and heroin addiction as community problems. It also offers some evaluations of methadone maintenance, which is the Nixon Administration's solution to the heroin problem. The final evaluation must be your own. My position, as a young physician-in-training, is that there is no medical or pharmacological solution to any social problem, even if it is ordered by the government.

My conclusion is that two wrongs will never make one right — even if one can be substituted for the other.

Drug Crisis in the Corps

by Robert S. Aaron '67

In October 1971, I began a year's tour of duty with the 3rd Marine Division, based on Okinawa. This division, with a proud and bloody history, represents the President's "Force in Readiness" in the Far East, and its 9,000 infantrymen, tankers, and support units are in a position to be deployed on very short notice anywhere in the Orient and as far west as India. The largest base houses and trains the 4th Marine Regiment and is called Camp Hansen.

The camp sits in the rural Orient, surrounded on three sides by rice paddies, and is well north of the congested, more Westernized part of the island. On its fourth side lies Kin Village, a town of several hundred, seemingly populated almost entirely by camp followers, prostitutes, bar-girls, pawn shops, and camera stores. Exotic and often untreatable forms of gonorrhea are exchanged nightly between residents of Kin Village and Camp Hansen with heavy incidence coming to light some three to seven days after payday. It is also a center for drug trade among Marines.

The Marine Corps is the infantry assault unit of the Navy and despite having its own chain of command, topped off by the Commandant of the Marine Corps, it is under the direction of the Chief of Naval Operations (Admiral Zumwalt — famous outside the military for his relatively modern ideas and Z-grams)

and the Secretary of the Navy. It has no doctors of its own, thus its medical support is derived from Naval physicians and corpsmen. Among Navy personnel, duty with Marines is considered a hardship tour, although the animosity is mixed with grudging affection and spirited and frequently violent competition — often in bars — much like a year's tour might be with your mother-in-law. The drug problem among Marines was therefore under the purview of:

SECNAV INSTRUCTION 6710.2

From: Secretary of the Navy
To: All Ships and Stations

9 July 1971

SUBJ: Exemption Program for disclosures of Drug Use and Possession Incident to such use.

> 1. Policy . . . it is the Policy of the Department of the Navy to eliminate drug abuse by the use of all methods that prove effective in combating this problem. One primary method is to encourage disclosures of drug use — through a program of Exemption. Members of the Naval service who make voluntary disclosures of such activities will, under terms of this instruction, be granted exemption from disciplinary action and from Discharge under other than honorable conditions. Disclosures will enable the drug abuser to obtain needed medical and psychiatric treatment, counseling, spiritual and moral guidance, and other rehabilitation, if such is feasible . . . Under no circumstances will this program be used to develop "informers" for the purpose of obtaining information that should be sought instead through normal investigative procedures.

The instruction went on to define "exemption," noting that it did not preclude modifying security clearances, duty assignments, flight status, etc.; it itemized the use of which drugs fell under its jurisdiction; it stated that exemption was a one-time affair. If a sailor or Marine were caught after signing up, he would be liable to prosecution. It noted that exemptees must sign up voluntarily, but those who had been "involuntarily identified" were given 24 hours to sign up for the program, thereby allowing a Marine who had been caught via the mandatory urine testing program, or by an undercover agent, to escape official punishment. This message included an interesting, if not a trifle optimistic, notion of "sincerity"; exemptees must be sincere to qualify for the program. Sufficient evidence for a member's sincerity was established by his "declared intention to cooperate fully in his own rehabilitation program," i.e., by signing up! Pushers were excluded from eligibility.

This instruction was issued several months before my arrival on Okinawa. Career Marines generally scoffed at it, but carried it out because it constituted orders from the Secretary of the Navy, John Chafee. From a practical point of view, all it did was identify some users, who were signing up and thereby admitting past use. To no one's surprise, at least 90 percent of all those I interviewed during my first month on the island signed up simply to avoid prosecution; others thought it represented a free ticket out of the service. Only the rare man actually discontinued the use of drugs.

In November 1971, I gave a talk to the physicians in my own unit, 3rd Medical Battalion, summarizing my views at that stage.

> The extraordinary thing about the heroin user is that for the most part, he is an unwilling patient and refuses to see himself as a patient. Most people I've evaluated don't want to get off drugs — except temporarily, to get the authorities off their back or to reduce their habit if it has become too costly. The Commanding Officer of the 3rd Medical Battalion is perplexed about why people take drugs. I don't have an answer for that. One of my patients said, "Everybody wants to get high." Our problem now is that people *do* take drugs and *do* want to get high, that *we* define it as a crime or an illness, and *they* do not. Is it any wonder that every drug program has been afflicted by enormously high relapse rates? In our present state of knowledge, we do not know how to cure drug addiction. The word "cure" is presumptuous since for the most part, the patient does not experience this as a disease; it is not an affliction but is intimately bound up with questions of his *will*. The medical model is a dead end . . .
>
> In this context, we are being asked to interest ourselves and advise in the running of the Drug Exemption Program. There is great confusion about whether or not it offers "rehabilitation." Lt. G, from the Division Drug Abuse Office, noted a few weeks ago that no rehabilitation is offered, and that seems to me a fair assessment of this basically administrative and user identification program. But a small number of exemptees do join in order to get some help. I have a letter from the Assistant Sec. of the Navy written to a disgruntled Marine in which the DEP is described as "offering the necessary rehabilitation to deal with drug addiction." *No one*, in or out of the Navy, can do that reliably. It is no wonder that confusion is widespread.

I went on to point out that at least 75 percent of exemptees continue to take drugs, directly violating the program, and jeopardizing their freedom. Such action breeds disrespect and makes a mockery of the program, which seems designed to be self-defeating. Few patients are able to discontinue their addiction at the stroke of a pen. Next I recounted many tales of unofficial harassment of exemptees, particularly by NCO's and company level (Captain and 1st Lt.) officers. Finally, I related an interesting side effect of a recent drug control effort:

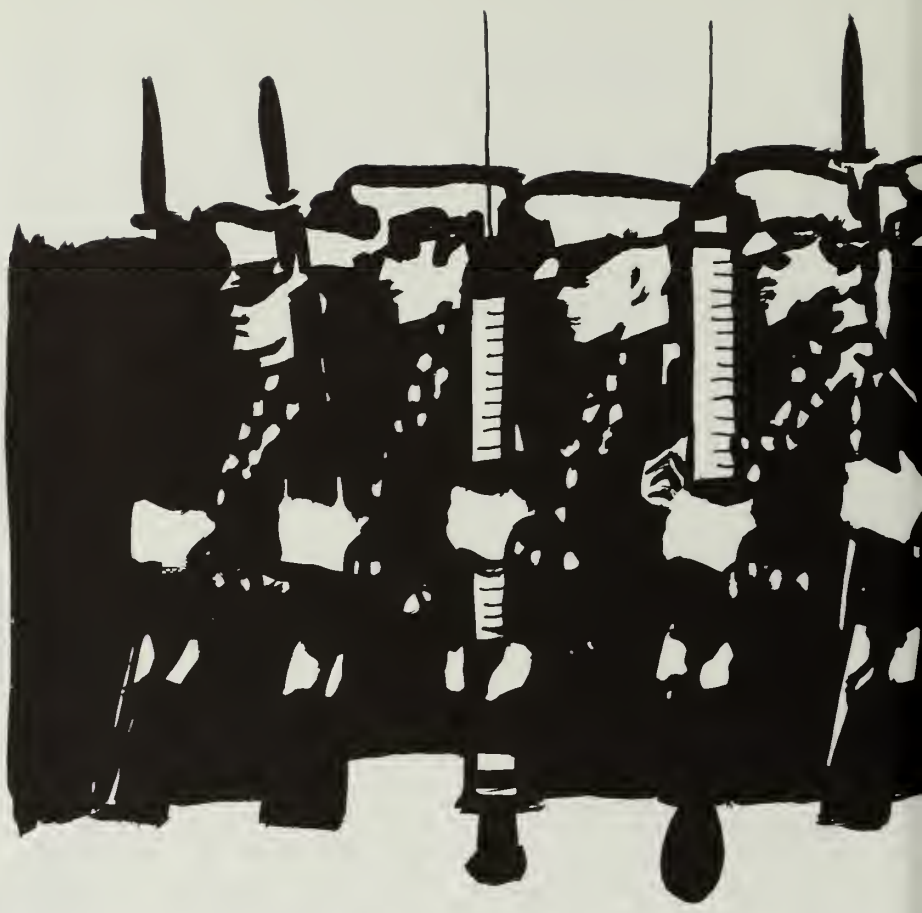
> Until around early October 1971, Marines on Okinawa could easily obtain marihuana. At that time, a crackdown on this traffic began, chiefly, according to my sources, because marihuana is easy to detect, bulky, dogs can sniff it out and so forth. The effort has been enormously successful; mari-

huana is exceedingly difficult to buy now; but one upshot is that Marines are turning to drugs that *are* available, namely heroin . . .

I had no idea how many Marines had turned to heroin because of the unavailability of marihuana, but I was confident of at least two cases that had come to my attention and many more I had heard of second-hand. Many months later, I was to read of a similar finding from the Navy's Drug Rehabilitation Center at Miramar, California. Over the next two months, I interviewed more intensely the Marines on the program and concluded what many officers had privately felt: that the program was a facade in which no one really had any faith.

In December 1971, the Division Commanding General rotated to a new position and a new CG took his place. I went to a reception honoring his assumption of command which took place in an impressive officers club overlooking the Pacific. Much drinking and hearty fellowship were in evidence and when my fellow division psychiatrist nudged us over to within hailing distance of the General, we introduced ourselves. I congratulated him and bluntly said, "I hope we can do something about this drug thing during your year here." We raised our glasses to toast the early demise of the problem.

Three weeks later, the general dropped by our battalion command post for a briefing. We talked about how many Marines, away from home for the first time in their lives, had a difficult time adjusting on the island. He seemd quite interested in how we might cope with the heavy use of drugs, particularly heroin, which had become apparent to him during his first month. Eventually, he was willing to approve a pilot drug program. In February 1972, our first group met in a field tent. As always, the roar of helicopters and artillery was in our ears; through slits in the tent, we could see the flash of white phosphorous shells and the ugly black smoke of the 105 mm howitzer rounds as they crashed into



a mountain slope about two miles away. In this setting, we did our work.

Seven months later, I sent the following letter to the General:

DIVISION PSYCHIATRIST
3RD MEDICAL BATTALION
3RD MARINE DIVISION (-)
(REIN)
FPO SAN FRANCISCO,
CALIFORNIA 96602

28 September 1972

From: Division Psychiatrist,
3rd Medical Battalion

To: Commanding General,
3rd Marine Division

Subj: The Failure of Division
Level Drug Rehabilitation

In January, 1972, a division-wide drug program was conceived by personnel in the department of psychiatry. The following month a pilot program was initiated and, by June 1972, a total of twenty USMC and USN enlisted men had participated. Of these, twelve had significantly reduced, on a short-term basis, their drug use while in the group; another man drastically curtailed his drug use after the group ended, while he continued for a brief period in individual treatment. On the basis of this experience, it was decided, with the Commanding General's approval, to expand the pilot program into a full-scale division program. The purpose of this paper is to discuss the failure of that program.

In its final form, the program called for all personnel on the Drug Exemption Program to be referred to the division psychiatrist; each would participate in a week-long group, meeting for an hour a day. The group's purpose would be to try to outline the kinds of problems, both mental and social, associated with drug-taking, to encourage introspection, to confront the usual

defenses employed by such patients, particularly externalization and rationalization, and to screen the participants for entrance into a traditional, long-term, once-weekly therapy group.

A total of 24 Marines and sailors went through such a screening group; each was given the opportunity to continue in a long-term group and six members chose that route. The others were returned to their units with no further follow-up planned. The senior corpsman in the clinic arranged to meet with the six patients who desired to continue; only one showed up the first night. Another meeting was planned with these volunteers; again one man, the same one, showed up. After a third meeting failed to materialize, the program was dropped. Interestingly, there is a division order requiring all new drug exemptees to be referred to our office. Since the initial flurry following institution of the order however, no referrals have been made. No new patients are coming our way and the program is effectively defunct.

In thinking about the reasons for the failure of this effort, several obvious points are worth discussing. First is the widespread official resistance to any sort of drug rehabilitation program. This resistance has been most apparent at the company C.O. level and below, and is expressed in many ways: for example, I immediately think of the virtual drying up of referrals despite a division order to the contrary. Another example occurred months ago, when the program was getting started; my corpsmen and I spent between ten to fifteen hours per week on the telephone trying to reach drug exemption officers who did not return our calls. There were exceptions to this phenomenon, but for the most part, passive resistance — failure to return calls, bungled appointment times attributable to commands or Drug Exemption Officers, command or NCO insistence that a man may not keep an appointment — was common and extremely effective in sabotaging our early efforts. Higher up in the chain of command, despite, no doubt, personal and private reservations, colonels and generals who received us did so with courtesy and enthusiasm. The tone of this reception was set by the Commanding General and his Chief of Staff. For instance, we had been meeting in a dilapidated tent for three months which threatened to wash away in a rainstorm and when this became known to the Commanding General, we were provided with a barracks in two days. I believe there is something to be learned from this: passive resistance emerged in its strongest form at the level of command having most to do on a day to day basis with the drug user; I am convinced that this resistance reflected the personal frustration these commanders and sergeants felt in their dealings with these men. Our efforts to overcome this resistance, in the form of meetings with the NCOIC of each man in the program, had in fact some success but required a tremendous expenditure of time and energy — and could not be realistically applied division-wide. In fact, the reality and the enormity of the problem faced by these commanders, responsible as they were for ofttimes recalcitrant, unhappy, impulsive Marines who were of little value to them and perpetually in trouble and, they felt, often "infected" "good" Marines, easily accounts for their anger. More often than not, their wish was for us somehow either to transform or dispose of these patients. Neither of these options in the long run, was available to us.

Easily matching or surpassing this passive resistance was the active resistance we encountered among many Marines in the Division. Drug users are simply not liked by nonusers, particularly when the nonusers are in positions of responsibility. Any effort to regard drug users as rather pathetic, inadequate persons in need of help, was rou-

tinely looked upon with skepticism and cynicism, if not outright condemnation. By their lifestyle, drug users openly challenge the ethic of hard work, delayed gratification, reward for achievement — the puritan ethic — that motivate career men in any profession. While open hostility was rarely expressed directly towards men or the N-P technicians who worked so hard to set up our initial program, it was common knowledge, even in our battalion, that various officers in charge were both derisive in their comments and undercutting in their behavior of our attempts. I point this out, not only because it is comprehensible, but because our battalion, even with its obviously heavy medical orientation, was no exception when it came to attitude and support for the ideas with which we were trying to experiment.

Beyond resistance from officers and NCO's, there was the profound resistance of the patients themselves. Drug exemptees, 90 percent by our survey of 75 men, joined the program either to avoid prosecution or to obtain a discharge. Only a tiny fraction perceived that they were experiencing internal difficulties. Overwhelmingly, our patient population was composed of a manipulative, psychopathic type who did not want help, resented our attempts, feared that they might be considered rehabilitated and be returned to full duty with expectations that they would complete their tour. In short, they were angry at us and were extremely resistant to therapeutic efforts.

In our initial pilot program, we devoted three hours a day, five days a week, for three weeks in group meetings. These groups of patients did, in fact, produce some remarkable results. Drug use in all three groups that completed the program declined markedly, as reported by the patients themselves in unsigned weekly notes to us. This decline seemed to me and the corpsmen in charge to be associated with a deepening self-awareness and the relinquishing of traditional defenses by

the patients. We attempted long-term follow-up of these 20 patients over a three-month period, but because of a shortage of personnel and continuous turnover in the division, this was impossible. There is no question but that some men in that phase of our work were significantly improved, possibly profoundly so. But our error was in thinking that small group meetings were in themselves therapeutic, and that this principle could be applied across the board. In the final phase, the division-wide setup, we, in effect, reduced the number and frequency of meetings, and, to our surprise, were unable to generate any enthusiasm for the effort.

The root of the matter is clear, it seems to me. We have been trying to apply the medical model to our patients; we have considered them "patients" with an "illness." This usually works when the patient has pneumonia or a broken leg; the gain from those illnesses is far overshadowed by the inconvenience and discomfort. With drug addicts, however, the individual rarely defines himself as the "patient"; he does not routinely seek help to rid himself of his addiction — the assistance he wants is to minimize the bad side effects and social consequences of his habit. It is no wonder then that there is such fierce resistance from our young men who are on drugs. From their point of view, we are being, simply, presumptuous.

There is universal disillusionment with drug programs: none, as far as I know, have demonstrated effectiveness over the longrange. This includes traditional psychotherapy, group work, and methadone maintenance. Our experiments here were successful beyond our fondest hopes, but only with an unrealistic investment of time and energy. The final program in retrospect was appropriate to our resources but inadequate to our goals. Keeping this in mind, for the future we cannot expect to provide effective drug rehabilitation programs at the division level. The only men we can hope to help at this stage of our knowledge, are the idiosyncratic cases, those few who are already well-motivated to stop taking drugs, and these men can best be helped at the level of local commands or through individual psychiatric care from this office. From the Division we should expect only that more experiments will be attempted, that our knowledge will slowly increase, and that, as Arrowsmith noted, "Perhaps we'll fail."

ROBERT AARON. LCDR. MC, USNR,
Division Psychiatrist

Aaron's Answer

Who are the experts? From what experience can we learn how to deal with this dreadful problem? I left Okinawa firmly baffled and remain so. More and more I am convinced that the only remediable aspects of the drug problem are those outside the "patient"; high crime rates, corrupt police, unconscionable insurance premiums, inconvenience at the post office and at customs, the involvement of organized criminals, my own unease when I leave my apartment and wonder how many of my possessions will be there when I return. We have created a large criminal class, whose crimes are a product of their habit. For the foreseeable future, drug addicts (heroin addicts a half-million strong by a CBS News account) are here to stay. In all of this, I have been neglected; I have been forced to pay their price, in taxes, insurance, inconvenience, and fear.

Heroin is one of the least expensive drugs. I feel it is time to legalize its use. I propose making it a prescription medicine for registered addicts. What would the test of an addict be? I do not believe any complicated procedure or history taking method would be worth the expenditure. The patient's say so is enough. Beyond an initial flurry of experimenters, I do not believe there would be large scale mobbing of heroin clinics by non-users. I propose retaining some notion that to be a heroin addict is to bear a liability and would make this liability known to prospective employers. My guess is that a well-maintained addict who does not have to steal for his heroin would be a better job-holder than he is under the present system. At the very least, some of the enormous social consequences mentioned above would abate somewhat. The cost of giving out heroin has got to be less than what we are paying now either in dollars or apprehension. If my prediction is wrong, we could easily return to the present fiasco of harsh enforcement and encampment.

As for the addict himself, we must resort, in the end, to questions of will and what it is that makes life worthwhile. My patients have almost universally been lonely, isolated individuals whose intense transactions with the world are in the minute sphere of dealing with one another and their pushers. Their waste is colossal in scope; and it is heartbreaking; and it is their choice. I have run out of research ideas; I would support others and demand results from pilot programs before expanding them. If there is help for the patient, if there is interest, if that quality that drew us into medicine in the first place generates ideas which will help, if we can learn, so be it. Let our money go into research, not police. And in the meantime, let us stop punishing ourselves by making a criminal of the addict and a victim of the citizen.

Letters

To the Editor:

May I point out two corrections related to my "Commentary" in the September-October issue. First, my title at HCHP is Director of Medical Planning. The Medical Director's position is ably filled by Dr. H. Richard Nesson.

Secondly, on page 20, it is stated that HCHP has enrolled 29,000 subscribers of which 2,500 are Medicaid recipients and 1,000 are subscribers through the Health Cost-Supplementation Program. In each place "members" should be substituted for "subscribers." Members include both subscribers and the dependents who are covered under the subscriber's contract.

Joseph L. Dorsey '64

Clarify and Define

To the Editor:

The recent article by Dr. Waitzkin and Ms. Cohen on HMO's deserves comment on a number of issues; primary among which is the authors' ready acceptance of the plot interpretation of the health care crisis as proposed by Health PAC. However, the statement "in our opinion enthusiasm for HMO's supported by national health insurance has helped divert attention from the fact that national health insurance will not solve the distributional crisis in American medicine," is partially false on two counts.

First, extension of the insurance principal to health care for all citizens would do a great deal to alleviate the fiscal problems of many rural health programs. The Farm Workers Health Service in the California State Department of Public Health, supports a number of migrant health operations in which services could be provided by main stream providers if reimbursement was available. Additional project funds could then be expended on facilitating services, such as transporation, patient advocacy, etc.

Second, the innovative potential of HMO's is directly relevant to the problem of the maldistribution of physicians. Certain kinds of efficiencies in medical care exist involving one to one physician patient contacts. These may be such things as the use of nurse practitioners or physician assistants or automated health screening. These efficiencies can exist for the solo practitioner as well as in the group practice setting.

Other "system efficiencies" are found only in association with the HMO concept. Rationalized utilization of the mix of outpatient/inpatient services account in large measure for the dollar savings attributable to the Kaiser operation as noted by Dr. Dorsey.

Other system efficiencies are also possible under the HMO concept. If the rural health care problem is viewed as a transportation problem, under the sponsorship of a large HMO, transportation of physicians and other health personnel to and from isolated areas is a distinct possibility. Within the average commute time, personnel scarce in rural areas can be transported from urban centers. I personally don't think that other expedients such as trying to change attitudes of physicians so that they will wish to live in rural areas is likely to be effective. Despite its many problems, the urban/suburban areas are likely to attract most persons as places of residence in the forseeable future.

Clearly such schemes will increase the dollar cost of services. However, the aggregate change in cost would be small in a large group enterprise. Also, I suggest that a compulsory system, centrally administered as suggested by the authors, would be insensitive to this kind of consideration. Especially in a cost conscious climate. Forced doctoring also would probably be unacceptable to the rural health consumer. However, strong regional HMO's could press for this type of innovation, thus increasing service availability and consumer satisfaction, not to mention the satisfaction of professionals providing services.

John J. McNamara '65

To the Editor:

I would like to add a few comments to your recent debate about the Harvard Community Health Plan. Waitzkin and Cohen propose to remedy the problem of maldistribution and increasing cost of medical services by instituting both national health insurance and a nationalized health service. Their quarrel, then, is not really with Health Maintenance Organizations per se, but with the development of HMOs as an alternative to more radical solutions. Dorsey effectively rebuts many of their specific criticisms of the HCHP. However, I would like to take issue with his concluding remark, which implies that HMOs ". . . offer a partial solution to the problems of manpower distribution in urban centers." My disagreement relates to two main points.

1. *In the absence of National*

Health Insurance, or some equivalent, HMOs will tend to serve that very segment of the population which is currently obtaining medical care — employed families receiving medical insurance as a fringe benefit — rather than the urban or rural poor. The reasons for this are simple. Given the current discontinuities and categorical nature of medical funding for the poor, the marketing and administrative efforts required to enroll and maintain such a group are prohibitive. This point has been effectively made by Blendon[1] and is illustrated by the enrollment data at HCHP. Currently only 3,500 (12.1%) of the Plan's 29,000 subscribers are from low-income families, and it would appear that as the Plan continues to grow the percentage of low-income families will drop.

It is far easier to ask an employer to deduct a monthly premium from salaries of employees electing to join an HMO than to deal with the maze of eligibility criteria and jurisdictional boundaries currently regulating the payment of health care for the poor. Similarly, the efforts involved in enrolling the widely scattered self-employed persons living in rural America create a disincentive to the enrollment of this group. The consequences are the selection of urban or suburban employed families as target populations for developing HMOs.

2. *Start-up and developmental costs for HMOs are very high.* According to the figures listed by Waitzkin and Cohen, the HCHP received approximately 4.5 million dollars in nonsubscriber income between 1968 and 1970. The plan has only just reached its theoretical break-even enrollment figure of 30,000 subscribers. Thus, an initial subsidy of approximately $150 per person was required for planning and development, in addition to the annual premiums charged for actual health coverage. Few other institutions have Harvard University's skill in obtaining public and private financial support, and private philanthropy for development of HMOs seems to be limited at present. It may be that congressionally authorized support for HMOs will be forthcoming, but the level of funding needed to establish sufficient numbers of HMOs to change the current maldistribution of physicians would be enormous, and one might legitimately question whether other solutions might not be more effective.

Thus, while I agree that HMOs can offer high quality comprehensive care in an efficient manner, I fear that, in the absence of substantial changes in the financing of health delivery, HMOs are not an effective solution to the maldistribution of medical services.

STEVEN A. SCHROEDER '64

To the Editor:

Waitzkin and Cohen in their article "A Critical Appraisal of the Harvard Community Health Plan" state that "under a National Health Service . . . physicians can be assigned to areas of need." They repeat this idea explicitly or implicitly several times and themselves support the idea that redistribution of medical care requires such compulsory measures. In his reply to their critique Dorsey seems to accept the same idea that a national health service, such as those in Russia, Cuba, China, or Great Britain compels physicians to serve in areas with unfavorable physician ratios. It is my impression that the above statements do not apply to the British National Health Service. I would argue that without such assignment of physicians to areas of need the British have to a great extent corrected the problem of maldistribution and that we can learn much from the British experience.

The British system works to my recollection as follows: If a general practitioner chooses to practice in areas in which there is a serious shortage he receives an additional payment above the usual capitation schedule. If he practices in areas with only a few vacant positions, he receives the normal fee. If an area is filled, the government will not pay the practitioner. The physician can practice in such an area, but must rely entirely on private practice earnings. Since it is rarely possible for a doctor to earn enough without health service support, doctors tend to move to areas in which vacancies exist. But I do not believe that any doctor is assigned to an area of shortage or is moved involuntarily to such an area.

The control in the specialties is slightly different, but still involves no assignment. The health service controls the number of trainees in each specialty by the simple means of financing only a limited number of trainee positions. Since in some fields the competition is intense, those who do not get training positions in the specialty of their choice either choose a less crowded specialty or go into general practice. The distribution of specialists is controlled by the simple mechanism that the health service allots to each hospital only a limited number of positions in each specialty. Vacancies are advertised, and the hospital or the regional board chooses the best qualified applicant. The trained specialist is never assigned to a position, but is free to apply or not as he chooses. By this method there has been achieved a much more effective distribution of specialists than existed before the health service.

I would point out that this system is no different from that prevailing in the United States in many areas. No one suggests that students are "assigned" to medical schools in this country, but all medical school positions throughout the country are filled because the number of positions in each school is limited.

I would suggest that a system in which the financing is controlled can achieve better distribution without the undesirable expedient of assignment. It is curious that this method of solution has received so little attention in discussions of health

[1] Blendon, R. J.: The Age of Discontinuity: the financing of innovative health care programs in poverty areas. *J. Hopkins Med. J.* 128: 24-29, 1971.

planning in the United States. I would suggest that such a system might not only achieve better geographic distribution, but also correct the gross overcrowding of many specialties, and would also provide a more reasonable ratio between specialists and primary physicians.

NORMAN GESCHWIND '51

BURACK BLASTS BACK

To the Editor:

From the vituperation in a certain three letters in the September-October 1972 issue of the *Bulletin*, published under the heading "Negative Comments Blast Burack's Rx," I gather that my article in the May-June 1972 issue (subsequently reprinted in the Congressional Record) must have hit squarely on the mark.

Three days before I received the September-October issue of the *Bulletin*, the phone rang in my office and a Dr. Fenimore Johnson of the Upjohn Company in Kalamazoo, Michigan, was on the line to invite me to "chair" a symposium on conflict of interest within medical schools, on December 5th in Chicago. The audience would comprise a number of "Professors of Medicine" in the Midwest. It would be an evening meeting at a plush club, with cocktails and dinner beforehand. He offered to pay my transportation, expenses, and a generous honorarium. Upon realizing that he represented Upjohn, I requested a few days to think it over. Upjohn, I figured, was not going to get Richard Burack into a position where anyone in the future could accuse him of taking anything that smacks of favors from the drug industry, a practice I have deplored among influential persons in medicine. Imagine my surprise, then, when three days later I found in your *Bulletin* a hostile letter by one Fenimore T. Johnson '43B, with absolutely no mention of his being a very high ranking executive with Upjohn. I wonder how many of your readers were aware of this little trick. Now, I find nothing inherently wrong with a doctor's working for a drug manufacturer provided such a doctor makes it clear when he writes in an eminent *Bulletin* or speaks as an authority at medical meetings that he is on the payroll of the industry. To do otherwise is to masquerade as an objective source of opinion or information — and this is what Johnson has done. I conclude that the gentleman is either insensitive or dishonest. I cannot respect him. So much for Johnson.

There is a second hostile letter by Charles C. Leighton '64. It is shockingly loose with truth. To be sure, Leighton does admit working for "a major drug firm," but anyone who has taken the time to read the many documented volumes of the Nelson and Kefauver Subcommittee Hearings knows full well the temerity with which these firms have time after time arrogantly distorted their advertisements and even "Dear Doctor" letters. By eliminating the first nine words and two commas from a sentence in my May-June article, young Leighton manages to change its meaning. Thus I wrote, "From my own busy, private practice of internal medicine, I know that 98% of all patients can be adequately treated with 25 or fewer drugs and some of these need be used only rarely." A fair-minded and experienced clinician would know from this that I was referring to drugs necessary to treat office and most hospitalized patients; that I was not referring to "general anesthetics," "therapeutic gasses," "radiopaque media," "narcotic antagonists," pediatric drugs, etc. However, Leighton would apparently pull any ruse to discredit me in the minds of readers who either have not read "Burack's Rx" in the May-June *Bulletin* or have forgotten its details. When I was a graduating medical student twenty-one years ago at the Bowman Gray School of Medicine of Wake Forest University, and later intern and resident on the Harvard Medical Services of the Boston City Hospital, a stunt such as Leighton tried would have earned him instant ignominy.

A third letter, from Raymond E. Jankowich '55, contains little important factual information. Instead, he dismisses what I wrote as a "glib harangue" and discovers in it a "tabloid fashion . . . not in keeping with the dignity of the *Bulletin*." He concludes with an *ad hominem* flourish: "It seems personal prejudices far outweigh reason in this article and the extrapolations are likewise biased." I do not profess to know what he pejoratively refers to as "tabloid fashion" and deny any intent other than to have been succinct, accurate as I could be, and hard-hitting. Jankowich had better take a second look at drug advertisements before he gets on his high horse over "tabloid fashion."

I believe wholeheartedly, as I wrote before, that the continuing dependence of all segments of the medical profession (especially its academic wing) upon drug industry "favors"*, and its refusal to acknowledge the existence of an overly-inflated industry feeding on an artificially-induced market in the field of health care are bound to get the profession into bad trouble.

I am grateful to Drs. Christopher Thron '59, and Sedgwick Mead '38, for their excellent letters in response to Dr. Young (The Persistence of Medical Quackery in America) and to me. Dr. Mead has written a particularly clear, courageous letter, behind which there must be a fine character and rock-like integrity.

RICHARD BURACK

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* The industry, according to one of its ex-executives who testified before the Senate, does not give favors; it makes investments.

ALUMNUS CALLS FOR NEW HMS DEPARTMENT

To the Editor:

Shortly after returning from the fiftieth reunion of my class at Harvard Medical School, I received and read the number of the *Bulletin*

which contained the article expressing the faculty's and student body's unanimous condemnation of our government's resumption of the bombing of North Vietnam. I was amazed (and I believe reasonably so) that an institution which has deservedly become famous for its wholly objective and unemotional search for the truth concerning the problems of the health of the human body (and mind) should suddenly come forth with this absolute and unexplained conclusion concerning the welfare of our nation and the science of society, a subject so complicated, so vital and so distinct from that with which the school was established to deal and has heretofore dealt. Coming as it does unsupported and unexplained at this time when the subject is so politically controversial, it can be interpreted as being emotionally and even politically inspired.

Both the science of medicine and the science of society are branches of the science of biology. This being so, it seems no unreasonable to insist that both be treated in the same objective, critical and expectant manner, and also to insist that if Harvard Medical School is to adventure into this new field, a field of all fields most deep and difficult, it should do as it has done in all the various branches of the medical sciences — establish a department to deal with it.

The subject is far from new. Since the first appearance of Homo sapiens, it has been man's great concern, and over the centuries has been considered by the finest minds that the species has produced. This being so, should not the first business of any scientist entering this field be to do as any scientist does in attacking any problem: familiarize himself with what has already been thought, said, and done on the subject. This would include a complete knowledge and understanding of the contributions of Thales, Pythagoras, Heraclitus, Herodotus, Parmenides, Empedocles, Plato, Aristotle, Euclid, Democritus, Zeukipus and all of the great minds in philosophy and science who since that time have applied these minds to this engrossing subject as diligently, comprehensively and as enthusiastically as did these great Greeks of the tremendous flowering of thought in the 6th and 5th centuries B.C. — such men as Roger and Francis Bacon, Galileo, Abelard, Thomas Aquinas, Pascal, etc., etc., down to Newton, Berkeley, Locke, Hobbs, Darwin and Wallace and almost any great figure one can name in science and philosophy. It would require a basic understanding of mathematics, which by abstraction and its insistence on absolute definition, is the greatest tool which man has invented for exposing fallacies and approaching truth. Since the phenomena of history are the only available data it would require a thorough grounding in history, which is a record not only of man's achievements and failures but is also an open book to an understanding of man's nature.

It is not long ago that men of such broad education and enlightened understanding were readily available. This was before Charles Eliot decided that seventeen and eighteen year olds were competent to decide what studies they would pursue; it was before John Dewey; it was before our uneducated educationists decided that Latin and Greek, being dead languages, should be dropped from the curriculum; it was before science and mathematics were separated from "the humanities"; it was before our uneducated reformers decided that history was a tragedy of errors; and it was before the chief responsibility of teaching our youth was turned over to youths scarcely older or wiser than those they taught.

I have said that it was not long ago that men of such broad education were not hard to find. Throughout the length and breadth of the land the great universities and colleges and the many, many small colleges (many of them parochial) offered a curriculum which served as an introduction and a stimulus to the pursuit of learning. A few of the most intelligent of their graduates, realizing that this truly was but an introduction and that education was a lifetime undertaking, went on to read wisely and think deeply and by so doing eventually became truly wise. No school produced many, but all together the number was large. Today they are all dead and today we must search not only the United States but the whole world to find one to head such a department as I have suggested for Harvard Medical School, men who in this field of the physiology and pathology of society are imbued with what Nicholas Cusanus described as a "learned ignorance" or men who could say with Bishop Butler, "Since things are as they are and the consequences of them will be what they will be, I do not see why we should try to deceive ourselves."

Everyone is naturally distressed by the horrors of war. This being so, it is natural for some to jump to the unwarranted conclusion that peace is good and war is bad. This is not so and never has been so. Certainly we should ask "For whom is peace good?" And perhaps we should be so reactionary as to argue with that arch conservative Edmund Burke who said, "In any matter concerning human affairs I refuse to give praise or blame to any principle in all the loneliness and nakedness of metaphysical abstraction. When men speak of liberty I must ask them 'Liberty for whom to do what?' " In this vein perhaps we should do as the medical or any other scientific investigator does before setting up his experiment: look up what already has been thought and said on the subject.

If Harvard Medical School wishes to speak authoritatively on this subject, should it not establish a department on the science of society; and should not the motto of this society be as it is for medicine: "Life is short and the art long to learn, investigation tedious, experience fallacious, experiment dangerous, judgment difficult and the truth obscure."

JEROME R. HEAD, SR. '22

Alumni Notes

1912

Joseph L. Murphy sends his greetings and writes: "Although my health remains fine, I retired in January."

1918

We deeply apologize to **Dr. James R. Lincoln** for our error in the Alumni Notes, September-October 1972. Dr. Lincoln *is* professionally active, maintaining office hours five days during the week and employing a medical secretary. He retains hospital contact as a member of the Honorary Medical Staff and is a member of the Countway Library which he makes use of at frequent intervals. It is, however, Austin W. Cheevers '14 whom Dr. Lincoln visited with in April, who is not in active practice.

1920

With a net income last year of $4.50, **Warner Ogden** is now "99½ percent retired." "My wife and I spend our summers on the St. Croix River between Minnesota and Wisconsin and our winters in Carmel, California. I'm in fairly good health except for occasional gout. Should give up steaks and liquor, but who minds a rare bit of gout anyway!"

1924

Acadia University, Wolfville, Nova Scotia, recently dedicated a new science building in honor of **Charles B. Huggins.** Dr. Huggins is the 1966 Nobel Prize Winner in Medicine for studies made in the late 1930's when his finding that female sex hormones could shrink prostatic cancer led to the first successful chemotherapy for a malignancy in humans. Dr. Huggins is now the William B. Ogden Distinguished Service Professor in the Ben May Laboratory for Cancer Research and in Surgery at the University of Chicago. Along with the dedication, a bust of Dr. Huggins, similar to one dedicated last April at the University of Chicago, was presented to Acadia, commissioned by Mr. and Mrs. Albert Pick, Jr. of Chicago.

Alberto Hurtado has been the first scientist to be awarded the newly created Bernardo A. Houssay Award by the Organization of American Estates. Dr. Hurtado is an outstanding investigator on the effects of low barometric pressure on human physiology. He has published several papers on hipoxia and is responsible for the discovery of the lower sensitivity of the respiratory center to carbon dioxide as a cause of "chronic mountain sickness," chronic hipoxia.

1925

Howard A. Patterson writes of his family: "One of the boys was seventh generation at the University of North Carolina and there followed four years of med school and five years of surgical training. The second boy is now a top architect holding top honors at Kent School, Williams College and MIT. My only daughter was an honor student at Westover and at Smith College, and worked as a research associate at Sloan Kettering, New York, N.Y. before marrying an oral surgeon and moving to the beautiful Schoharie Valley with her husband, her children, and her ponies." Dr. Patterson notes that "as a past president of the American College of Surgeons, I was greatly entertained by the fact that the three chief officers-elect of the College are all HMS graduates. We have had quite a few 'Brighamites' as presidents including Robert M. Zollinger, Jr. '59, J. Englebert Dunphy '33, Loyal Davis, Frank Davis, and myself. It really is a great medical school."

1926

Everett D. Kiefer writes to us from New Hampshire to say that he's still in active part-time practice with the Laconia Clinic.

1929

Charles Bradley joyously announces he is "retired and enjoying it!"

A testimonial dinner was held in honor of **Duane Carr** and his wife in Memphis, Tenn., on Sept. 21, 1972. Dr. Carr was recently named clinical professor of surgery emeritus at the University of Tennessee Medical Units following his retirement from active practice Sept. 1, 1972. He was the first trained thoracic surgeon to practice in Memphis and founded the thoracic surgery training program at UT which has produced many chest surgeons.

George H. Humphreys is "now totally retired from clinical surgery, but continues a teaching assignment at P&S."

Now that he's fully retired, **Albert E. Morris** notes: "The throwaway journals and drug samples have stopped coming."

For a quick "catch-up" of his children, **Albert Quintiliani** reports: "Albert Jr. has been appointed assistant professor of medicine (dermatology) at the University of Washington Medical School. Richard is chief of infectious diseases and assistant director of medicine at the University of Connecticut Medical School . . . and I'm still practicing part time."

1930

Edward S. Rogers writes from Arizona: "We are enjoying life in Green Valley. Last June, two years after retirement from the faculty at U. C. Berkeley, I was invited back to receive the Berkeley Citation 'for distinguished achievement and notable service to the University'."

1933

Charles F. Ferguson has co-authored a 600-page textbook entitled *Pediatric Otolaryngology,* (Saunders, Philadel-